HELSINKI SCHOOL OF ECONOMICS (HSE)
Department of Accounting and Finance

BECOMING HYBRIDIZED PROFESSION?

The role of management accounting among medical professionals

Accounting
Master´s thesis
Hannu Puhakka
Spring 2008

Approved by the Council of the Department 19 / 8 2008 and awarded the grade excellent, 80 p.
Tarkastajat:
KTT, Juhani Vaivio
KTT, Teemu Malmi

HELSINKI SCHOOL OF ECONOMICS
Department of Accounting and Finance
Hannu Puhakka

ABSTRACT
12.06.2008

BECOMING HYBRIDIZED PROFESSION? THE ROLE OF MANAGEMENT ACCOUNTING AMONG MEDICAL PROFESSIONALS

Objectives of the research

This study aims to contribute to the existing hybrid literature by improving the understanding of the management accounting adoption process by medical professionals. The research is conducted by updating the hybridization perspectives presented by e.g. Kurunmäki (2004) who argued that in health care sector a fundamental transition would have taken place and accounting and medicine were hybridized.

Methodology

The research was conducted as a case study by interviewing seven persons. They all were in mid or late career phase. Younger professionals were excluded because the aim was to observe the perspectives from role identity reconstruction. Four of the interviewees represented nursing line, two physicians and one controller was chosen to give valuable information on the cooperation between professions.

The findings of the study

Our empirical results strongly disagree with the intensiveness of hybridization argued in prior studies. Although clinicians interviewed had a positive attitude towards the importance of management accounting; they perceived their participation to financial administration highly constricted.

Municipalities had initiated that financial responsibility ought to be directed to clinicians. Regardless, discovered evidence was controversial compared with prior studies in Finland. The dual role of municipalities was perceived challenging, physical structures (information systems, physical location) limited clinicians to access the financial information and strong jurisdictional disputes among clinicians weakened their cooperation thus having a negative impact on adapting management accounting.

Keywords

Hybridization, hybrid, management accounting, role identity, polarization, profession

HELSINGIN KAUPPAKORKEAKOULU
Laskentatoimen ja rahoituksen laitos
Hannu Puhakka

TIIVISTELMÄ
12.06.2008

BECOMING HYBRIDIZED PROFESSION? THE ROLE OF MANAGEMENT ACCOUNTING AMONG MEDICAL PROFESSIONALS

Tutkimuksen tavoitteet

Tämän tutkielman tarkoituksena on täydentää nykyistä hybridikirjallisuutta syventämällä ymmärrystämme johdon laskentatoimen omaksumisprosessista lääketieteen ammattilaisten toimesta. Tutkimusta on lähestytty päivittämällä hybridisaation näkökulmia, joita esim. Kurunmäki (2004) on esittänyt. He väittivät perustavanlaatuisen muutoksen tapahtuneen ja näin laskentatoimen ja lääketieteen hybridisoituneen.

Metodologia

Tutkimus suoritettiin case-tutkimuksena haastatellen 7 henkilöä. Kaikki haastateltavat olivat uran keski- tai loppuvaiheessa. Nuoremmat ammattilaiset rajattiin tutkimuksen ulkopuolelle, sillä tarkoituksena on lähestyä rooli-identiteetin jälleenmuokkaamisen näkökulmasta. Neljä haastateltavaa edusti hoitajalinjaa, kaksi lääkäreitä sekä yksi taloussuunnittelija tuomaan arvokasta informaatiota yhteistyöstä ammattien välillä.

Tulokset

Tutkimustuloksemme ovat kiistanalaiset verrattuna aiemmissa tutkimuksissa väitettyyn hybridisaation intensiivisyyteen. Vaikka haastatellut kliinikot suhtautuivat hyvin positiivisesti laskentainformaation tärkeyteen, kokivat he osallistumismahdollisuutensa taloushallintoon olevan rajoitettu.

Kuntien aloitteesta talousvastuuta tulisi suunnata kliinikoille. Kuitenkin tutkimustuloksemme ovat ristiriidassa Suomessa tehtyjen, aiempien tutkimuksien kanssa. Kuntien kaksoisrooli nähtiin haasteellisena, fyysiset rakenteet (tietojärjestelmät, fyysinen sijainti) rajoittivat kliinikoiden pääsyä talousinformaatioon sekä vahvat toimivaltakiistat kliinikoiden parissa heikensivät heidän yhteistyötään, näin vaikuttaen negatiivisesti (johdon) laskentatoimen omaksumiseen.

Avainsanat

Hybridisaatio, hybridi, johdon laskentatoimi, rooli-identiteetti, polarisaatio, professio

TABLE OF CONTENT

1 INTRODUCTION

1.1 BACKGROUND OF THE STUDY

One can discover hybrids in forms of organizational arrangements that cannot be categorized by conservative insights of hierarchies or markets. Also processes, practices and expertises can be perceived as hybrids. From a more general perspective, a hybrid is a new combination of two or more, commonly separate objects. As Latour (1993) and Miller & O'Leary (2007) express, there are enormous amounts of intermediaries constantly merging into dissimilar elements. Hybrids can stabilize themselves as institutions, start hybridizing all over again or even revert. Impurity is thus characteristic for all hybrids. Miller (1998) define even accounting itself as a hybrid, because of the constant reforming nature of it with other disciplines as engineering and economics. (Miller et al., 2007)

The empirical findings from Miller et al. (2007) emphasize the confused state which goes beyond the traditional ideology of risk management. When medical expertise and accounting are mixed up, conventional and also hierarchical methods are insufficient (see Kurunmäki, 2004). Thus, if we want more extensive insight of the dynamics of hybrid processes – the means of how separate elements blend and form something new which is able to manage uncertainty with approved accuracy – "we need to address the hybridizing of the practices, processes and expertises that makes this possible" (Miller et al., 2007). This can be attained by examining industry- and firm-specific practices that improve information progression and communication beyond organizational boundaries and experts.

Recent interest within academic world has shown substantive analysis of how accounting mixes up in and promotes the cross-border collaboration and the management of risk (see van der Meer-Kooistra & Vosselman, 2000; Langfield-Smith & Smith, 2003; Dekker, 2004; Kurunmäki & Miller, 2004, Miller & O'Leary, 2007). Kurunmäki's (2004) research illustrates how in health care sector, where organizational culture was dominated by medical professionals and accountants were seen as secondary information providers, a fundamental transition took place.

However the empirical evidence of Kurunmäki's (2004) study was collected in the first half of 1990s. Thus there is a need for an up-to-date inspection of how accounting and medicine have evolved after the birth of demonstrated hybridized profession. It would be interesting to observe the situation after a decade, how the adaptation process has developed and to examine current attitudes towards accounting.

1.2 Objectives and research question

This study aims to contribute to the existing hybrid literature by improving our understanding of the adoption process of management accounting by medical professionals. There are earlier studies of hybrid professions especially in health care sector but they only illustrate the birth of a new profession. Thus this study aims to bring new and valuable information of the topic by examining the adoption process. Consequently, the research question is:

How have medical professionals adopted management accounting methods in a context of public health care?

Furthermore, this objective is approached from role perspective. If medical professionals have acquired management accounting expertise, as was illustrated by Kurunmäki (2004), there should be evidence from positive attitudes towards accounting. Thus it shall be examined of how has the role of accounting changed from Kurunmäki's (2004) study and how it has been accepted.

1.3 Methodology and motivation

The empirical data for this study was gathered through interviews. By collecting the data face to face validity and reliability can be better evaluated when compared to survey methods (McKinnon, 1988). However the main advantage is the flexibility. The researcher can fluently

react to occurred circumstances and thus ensure more possibilities for interpretation of results. On the other hand, interviews are relatively time consuming and they demand both good preparation and advance consideration. (Hirsjärvi et al., 2004)

For this study seven semi-structured interviews was arranged. Themes for the interviews were prepared in advance and discussed with the interviewees but they didn't receive accurate format of how the events would be examined. Thus the researches enjoyed the freedom of directing the conversation towards appropriate direction. There were six clinicians and one from accounting department chosen to this study. They all were in mid or late career phase. Younger professionals were excluded because the aim was to observe the perspectives from role identity reconstruction. Four of the interviewees represented nursing line, two physicians and one controller was chosen to give valuable information on the cooperation between professions.

1.4 Structure of the study

The study is structured as follows. Chapter two is dedicated for enlightening the theory behind hybridized profession. The section starts by deepening the concept of hybrids, how it is seen among multidisciplinary academics, continues to how medical professionals have adapted accounting in Finland but also in other European countries and ends up in role and identity reconstruction theory.

Chapter three presents the study methodology and in fourth section the empirical results from the case organization, a psychiatric division of Hospital District of Helsinki and Uusimaa is processed. Fifth chapter illustrates the conversation between theoretical framework and empirical results and sixth concludes this research.

2 THEORETICAL FRAMEWORK

2.1 TOWARDS UNDERSTANDING THE CONCEPT OF HYBRIDS

Early as in 1970s Ouchi (1979) introduced a mode of control that didn't fit into the traditional ideology of hierarchies and markets. In next decade several researchers went further and stressed the importance of cooperative relationships (see Powell, 1985). Eccles (1981) for instance sees that the identification of the term *quasi-firm*, which refers to a certain organizational form where both parties can gain from investing in the process of learning to work in cooperation, accelerated the interest towards relational organization forms (Miller et al., 2007). In several different industries, as airline, oil and biotechnology, the organization of economic activities evolved more widely than traditional categories of markets and hierarchies could explain (Powell, 1987).

Regardless, hybrids were seen as a product of separated organizations when coming to the end of 1980s (Borys & Jemison, 1989), thus the firm boundaries were still emphasized. Powell (1990) appealed that the attention should be focused on network relations, where parties could take mutually parallel actions and could have the right of acting so at the expense of others. Later they used biotechnology as an example where the core source of innovation wouldn't be within restricted organization boundaries but in the cooperative actions of firms, universities, laboratories and customers (Powell, Koput & Smith-Doerr, 1996).

Other researchers found similar evidence, where social networks were emphasized (Barley et al, 1992). Gulati (1995) argued after the growth of interest towards inter-firm relationships that traditional transaction cost theory[1] view was too narrow. According to that theory, they continued, alliance members are viewed as independent organizations and only transaction costs

[1] Das and Teng (2001) opened the Transaction Cost Theory by conducting that the risk within interfirm relationships is a consequence of bidirectional goals of two independent companies who lean towards opportunistic utilization of trust relationship.

were to be studied thus leaving out the possibility of a continuum. Theory suggests that social factor emerges only in process of time (Gulati et al., 2000).

Zaheer and Venkatraman (1995) stressed the importance of relational governance, where trust between parties of inter-firm relationships should be more studied. Only recently there has been growth within that area (see Langfield-Smith & Smith, 2003).

Factors like adaptability to rapidly-shifting market conditions, the limitations of large companies and accessibility to special know-how beyond organizational boundaries can be understood as key accelerating factors influencing the growth of hybrid forms. Despite the increasing interest, the analysis is restricted by organizational forms. A wider perspective of hybrids with boundary-spanning activities is needed. (Miller et al., 2007)

2.1.1 Hybrids from the perspective of economists and social scientists

The perspective of economists considers the hybrids as one mode of governance along with markets and hierarchies (Williamson, 1991). Holmström and Roberts (1998) however continued that a much wider perspective should be needed in order to understand the richness of economic activities outside organization boundaries. They see the perspective of transaction cost economics also as too narrow focusing on asset specificity. Holmström and Roberts stress that the theory explains the problems common to the ongoing organizational change (incl. trend of outsourcing) like hold-up problems by integration. Regardless, many evolving hybrids with asset specificity and uncertainty do not end up in integration. On the contrary, Holmström and Roberts' findings address that mutual dependency motivate organizations into cooperation beyond firm boundaries. Miller et al. (2007) see organizational knowledge and information transfer as an explanation.

Roberts (2004) have found similar evidence. When the outsourcing and concentration into core functions have been growing, the nature of relationships has also encountered a change. As Roberts see it, the focus has shifted from arms length relations into long-term partnerships. They

continue that also changes in in-house activities could have been identified: the vertical integration has increased and line managers have begun to be more accountable for their actions. The key has been, in their opinion, horizontal communication.

Legal theorists emphasize responsibility in hybrids (Miller et al., 2007). Collins (1990) sees the issue of representation right as a continuation. Thus it is important to recognize the legal entity that is liable for actions done by its members. Collins continues that the collective responsibility should be widened to consider "complex economic organizations", which are a combination of separated entities that function as an integrated form.

2.1.2 Deepening the understanding of hybrids – accountants' insight

In the mid 1990s Hopwood (1996) claimed that although management processes constantly outreach the organizational boundaries the accounting practices are still based on hierarchical relationships and vertical information flows. They continued that transversal communication is commonly neglected. Hopwood appealed for more general interest towards network relationships, to go beyond hierarchical world of ideas.

Recent interest within academic world has shown substantive analysis of how accounting mixes up in and promotes the inter-firm collaboration and the management of risk (see van der Meer-Kooistra & Vosselman, 2000; Langfield-Smith & Smith, 2003; Dekker, 2004; Kurunmäki & Miller, 2004, Miller & O'Leary, 2007). In all of these researches the key emphasis has been on the lateral information flow and the activity beyond the traditional concept of organization. (Miller et al., 2007)

Miller & O'Leary (2005a, 2005b, 2007) have examined the hybridization process of financial and technological trajectories. Their empirical study of semiconductor manufacturer Intel is a good example of how two different disciplines, technology roadmaps and financial management,

mix up. Miller & O'Leary define technology roadmaps as information sharing framework[2] within semiconductor industry and those are used to inform investment appraisals. With the help of roadmaps Intel gains access to manage resources of a virtual firm. Thus by updating and negotiating the database and by exploring its contents before strategic investment decisions Intel's executives interface with a hybrid organization, which is a compilation of semiconductor branch companies, universities and even governmental institutions. (Miller et al., 2007)

In Intel's case, it is dependent of other actors functioning towards the collective direction. As Miller et al. (2007) express it, if other organizations don't act for the common good, the whole hybrids returns on investment in new product development and markets may fall drastically. Thus it is justified to argue that technology roadmaps make risk manageable by hybridizing technological and financial perspectives to develop together and by enabling separate actors to combine their mutual expectations as a virtual company (Miller & O'Leary, 2007).

Maybe the most recognized version of hybrids in Intel's case is the so-called Moore's Law, named after the co-founder of Intel Gordon Moore. He estimated in 1960s that the amount of electronic elements on a chip is to be doubled every three years while the costs per element would decrease annually around 29 percent. As technology road mapping could be seen crucial to the lateral flow of information and inter-firm risk management, then Moore's Law is surely a good illustration of hybridization where technological and financial components are combined. (Miller et al., 2007)

Hopwood's (1996) appeal was also more general; it included the idea of accounting hybridizing itself when researchers would concentrate on lateral information flows. As they (Hopwood, 1983) had said earlier, accounting "becomes what it was not". In Miller's (1998) words, accounting was shaped and reshaped during the last decades mixing up with other disciplines such as engineering and economics. Miller et al. (2007) continue by arguing that accounting is an ideal example of hybridizing, when practices like standard costing and break-even analysis have been educed from elsewhere and are now core practices of accounting.

[2] Technology roadmaps can be identified as hybrids by definition, because they are information sharing networks, combinations of individual actors.

Whether considering hybrids from the perspective of actor-network theory or "techno-economic networks", there has been the same stimulus: to examine the variety of hybrids evolved from the crossing point of two or several originally separate parts. Thus no *a priori* definition has been entailed nor been done any strict classification of their purpose. Almost anything can be perceived as a hybrid. They don't demand organizational forms albeit there hybrids can be located. (Miller et al., 2007)

2.2 Encounters of discrete professions – becoming hybridized expertise?

Kurunmäki (2004) argues that the formation of inter-professional hybrids has gained considerable attention in academic debate. Abbott (1988) appealed already in late eighties that professions should be studied as an interdependent entity rather than separate objects. They argued that in this entity abstract knowledge would be the success factor in order to avoid jurisdictional disputes and continuous competitive game. Abbott continued that abandonment of single profession studies is endorsed and recommended that one should focus on accounting in the factual connection of inter-professional relations.

An interesting example of inter-professional relations was shown by Kurunmäki (2004) when the hybridization of medical and financial expertises was examined in Finland. The study is based on the ideology presented by Abbott (1988). Kurunmäki notes that jurisdictions ought to be studied, especially do jurisdictional disputes arise, however emphasizing that they shouldn't be assumed *a priori* of professions. Encounters of professions within the system can evolve in hybridization or as well in competition. A key role is played by how lateral information flow and discrete technique mobility among professions are organized, rather than focusing purely on abstract knowledge (as was argued by Abbott). (Kurunmäki, 2004)

Miller et al. (2007) argue that the progression of financial expertise to be merged into other expertises continues to grow. Regardless, one should notice that next presented examples verify that hybridization isn't benign, nor that it would have an inevitable positive impact on risk management. As Miller et al. (2007) argue they demonstrate that plenty of activities fall outside

of traditional risk management and that the characteristics of hybrid processes, practices and expertises are vital to the competence of managing uncertainty across domains.

2.2.1 Special features of Finnish Health Care

Public health care in Finland is organized on the basis of localized population responsibility. After conducted reforms in 1993 municipalities are obliged to ensure the needed health care for its residents by producing the services or by outsourcing them. In 2004 there were 444 different municipalities, thus the finance system is highly decentralized. The obligation was expected to increase competition between hospital districts and public and private sectors. The basics for open competition are however complicated due to the dual role of the municipalities; they represent the owner and the client at the same time. (Saarni, 2005)

The ethical codes for physicians emphasizes physicians' important role in making priority decisions in health care because of their expert knowledge. What is seen although vital is that the role of a clinician should be diverted from the role of an administrative physician. When a physician is playing the role of a clinician, the person should have autonomous right to decide. However when participating in administrative positions, physician is no longer decision-maker rather an expert. (Saarni, 2005)

2.2.2 Hybridization in the context of New Public Management reforms

Early attempts to combine medicine and financial knowledge could be noticed already in 1960s, but the major impulse occurred after the decline in the world economy in 1970s (Rose & Miller, 1992). More credible accountability and management with more efficient usage of resources were insisted from all public service operators (Hopwood, 1984). Reforms conducted in next two decades emphasized thus the wastefulness, a result of deficient managerial and accounting practices, not directly the abstract knowledge or the autonomy of medical professionals. Reformers pursued to diminish the diversities between public and private sectors, to abandon process accountability ideology and to replace it with output accountability (Hood, 1995). In

health care sector, where organizational culture was dominated by medical professionals and accountants were seen as secondary information providers, a fundamental transition was expected. Medical decision-making were to be bound to a network of financial planning and calculations. New financial controls would maintain clinical autonomy but would possess the potential to "alter the exercise of power within the medical field". (Kurunmäki, 2004)

Kurunmäki (2004) describes the progression in Finland which began in the late 1980s when senior clinicians were made accountable. These health care reforms signify only a part of the administrative restructure process called New Public Management reforms (Hood, 1995). The whole process evolved such a way that centralized planning was substituted by decentralized management, and efficiency and effectiveness were emphasized (Kurunmäki, 1999). Ideology of results management initiatives was thus introduced – Management by Objectives became as the norm (Kurunmäki, 2004).

Decentralized management and budgeting experiments initiated in late 1980s in Finland, mainly in local, individual institutions (Enckell, 1998). Also the participated clinical units attended voluntarily. By directing the responsibility of budget preparation to medical professionals, they were combined into calculation networks (Miller & Rose, 1991). The key success factor in the hybridization was this voluntary basis of participation and the experimental nature of the process. The process developed rapidly and the acquisition of financial expertise was perceived uncomplicated when it was set besides the constant updating of medical expertise. (Kurunmäki, 2004)

What was seen also important was the participation of medical professionals in the early phase of budgetary process. This commitment was also tightened by making clinicians responsible to municipal representatives and hospital management for keeping within their budgets. The response from medical professionals was their increased demand for accounting information. Thus Chief Physicians and Ward Sisters were allowed to access to the accounting systems. Hybridization process had emerged from localized experiments and delegated budgets towards commitment and acquisition financial accounting knowledge. (Kurunmäki, 2004)

New Public Management reforms in Finland were strengthened at the beginning of the 1990s parallel with the progression of western economies (Olson et al., 1998). Welfare services continued to be publicly financed, but the service provision transformed. The role of the state, or local authorities, became only a purchaser of the service, where public provision was to be substituted with competing independent providers (Kurunmäki, 2004). Kurunmäki continues that rolling 5-year national budgetary system and the backing up system of government were replaced by the ideology of the market. Thus, as Buxton et al. (1991) argue, hospitals were forced to develop their financial management systems in order to survive the encouraged competition. They continue that traditional ideology of cash management (in-patient day and out-patient visit costs) was to be replaced with more sophisticated systems.

Although Chief Physicians were concerned by the large proportion of fixed costs, they saw reforms as an increasing factor of freedom in management of resources. As they expressed it, now nobody couldn't hide oneself behind bureaucracy and accuse politicians – they were obliged to manage the financial resources and thus were responsible for their own actions. Accounting was seen as an important skill that would enable to answer to the market conditions and thus the training of financial knowledge would be demanded as a part of medical education. (Kurunmäki, 2004)

At the end of 1990s hybridization of medical expertise was born. Management accounting tools were seen mobile to other professionals and thus medical expertise was perceived more widely. Clinicians' enthusiasm to gain the knowledge of financial planning questioned even the special support of hospitals' financial units. Interviewed Chief Physicians underline their sufficient knowledge of accounting practices, so clearer authority relationships were needed. As was expressed, issues of power and autonomy were highlighted – whether Finance ought to make the decisions or purely support the decision making. Especially in private hospitals the role of Finance Managers was emphasized: clinicians didn't have as a strong negotiating power with what to compete with. (Kurunmäki, 2004)

Kurunmäki (2004) argues that the basis of this successful hybridization was the transfer of techniques, while the abstract knowledge didn't involve significantly. Although, experiences in

the UK have been opposite when compared with Finland. Medical professionals showed initially slightly positive interest of gaining management accounting knowledge, but the compulsory attitude towards utilization of reforms didn't persuade clinicians. Hostility described the common opinions. Medical professionals perceived themselves accountable only for their clinical judgments, not for financial aspect. Kurunmäki et al. (2003, 2006) explain that it is seen as management accountants' assignment to justify overspending as required expenditure. Thus a clear jurisdictional dispute occurred in the UK between medicine and accounting. (Miller et al., 2007)

Kurunmäki (2004) claims that the success of hybridization in Finland could be explained by the "historical development and institutional location of accounting within the Finnish academy". She continues that inspired by the cost management information demand of World War II, the management accounting merged into business economics. The education system, including business schools, universities, also technical and commercial schools, came to arrange accounting learning possibilities. De Beelde (2002) presents that the accounting training system in Finland, similar with other Nordic and Continental European countries, differs from Anglo-American countries. Thus in Finland medical experts were more willing to adopt accounting practices.

2.2.3 Polarization as an alternative direction?

Where Kurunmäki (2004) demonstrated that accounting techniques and practices were acquired by all medical staff and thus modifying the nature of medical profession, Jacobs (2005) suggests the idea of polarization[3]. In social sciences polarization is used to describe the separation of a group into sub-units on the grounds of class, gender or other characterization (Keefer and Knack, 2002). Jacobs describes the process by two emerged sub-groups, other focusing on financial and administrative responsibilities while another is let alone, unchanged to practice the core function of health care practice. The fundamental difference between hybridization and polarization is, Jacob continues, whether all medical staff is included or just limited number of them.

[3] Originally term polarization was used in discriminating light waves in optics (Jacobs, 2005)

Kurunmäki's (2004) argument for acceptance of accounting practices in Finland was less formalized and powerful accounting profession and management accounting was seen as transferable set of tools available for everybody willing, not just property of accountants. In UK the situation was the opposite because accounting professionals maintained control over accounting practices. From this perspective Jacobs (1998) suggested that reforms would be more effective if accounting wouldn't be perceived as a threat to medical autonomy and it would be attached to medical education. Thus accounting wouldn't get the form of governmental or managerial control (Jacobs, 2005).

The process of polarization introduces a new, separate group, the medical manager. This group represents hybridization, medical professionals who had gained the understanding of managerial and financial knowledge. The example from UK illustrates that in a situation where a doctor is at the highest level of organization and there are no accountants or managers at unit level, the medical manager group is encouraged in management. (Jacobs, 2005)

Another aspect in polarization is the limited number of participants in accounting education and training. In UK only clinical directors were able to attend. Similar evidence was found in Italy and Germany. Results from these countries also indicated that although factual connection of medicine had expanded, there were no significant changes in values and practices. The polarization perspective explained that the, relatively enthusiastic-minded medical manager group absorbed the changes and enabled others to concentrate on caring. (Jacobs, 2005)

The idea of polarization is controversial. It accepts the fundamentals of hybridization, where medical professionals have gained the knowledge of accounting, but argues that different sub-groups, other accepting and focusing on accounting and other remaining static, exists. It seems to leave "...the fundamental values and practices of the wider profession unchanged" (Jacobs, 2005), not promoting the competitive attitudes against hybridization. Thus in this thesis polarization is perceived as one form of hybridization, namely sub-hybridization, not as an alternative path.

2.3 RECONSTRUCTION OF PROFESSIONAL ROLE IDENTITY

2.3.1 Perspectives of role identity research

Organizations where professional performance is crucial, as in hospitals, it is important to understand the roles and identities underlying human actions. Pratt & Dutton (2000) define professional identity as individual's self-definition within a profession through which the professional role emerges. According to Ashforth (2001) role identity consists of personal "goals, values, beliefs, norms, interaction styles and time horizons that are typically associated with a role". When trying to examine how professionals interpret encountered work situation, it is central to understand the way they see their role identity.

As illustrated in previous chapters, physicians' have shown reluctance to change their traditional role identities (see also: Fiol & O'Connor, 2006; Reay & Hinings, 2005), although opposite evidence exists (Kurunmäki, 2004). Thus medical field is tempting area of research in studying the dynamics underlying professional role identity, especially in a situation of reconstruction, where experts are forced to encounter new methods. The medical reforms conducted in Finland in late 90s offer a fruitful ground.

Chreim et al. (2007) examined how physicians have experienced their role identity changed during health care reforms in the late 1990s. The study was conducted in a Canadian health clinic where new health care innovations had forced the organization to evolve from governmental funded unit towards an accountable business unit. Health care innovations driven by Regional Health Authorities included also several other changes, e.g. compensation renewal and multidisciplinary approach to service delivery. Thus the issue of professional identity were seen as an important theme.

Traditionally in research of a role identity there are two distinctive literature streams, often described as macro and micro approaches The first mentioned views professional roles from a structural perspective, thus they are seen as fixed within institutionalized systems. As Abbott explains (1988) professionalism is defined by institutionalized beliefs and values and thus

professions can exercise control by training, testing and setting principles for actions. Chreim et al. (2007) argue that "thus the view is that strong identification inducement processes shape the identity of members of developed professions". Although macro level approach has been adapted to academic understanding of how institutional mechanisms define expertise roles, it doesn't provide sufficient explanation how they act within micro context. Micro level research emphasises the individual-level dynamics, i.e. on micro level individuals construct professional role identities. (Pratt et al., 2006)

2.3.2 Framework of interlevel influences on the role identity

In a framework created by Chreim et al. (2007) was sought to understand the impacts of interlevel influences on professional role identity reconstruction. They combined micro and macro perspectives and integrated institutional and individual approaches to interlevel examination. Figure 1 illustrates how institutional, organizational and individual dynamics influence the reconstruction of professional role identity. Institutional-level factors enable transition in organizational-level factors, which in turn affect the micro-level elements incl. new behaviours ultimately creating new professional model. These dynamics, their interactions and meanings are opened up below.

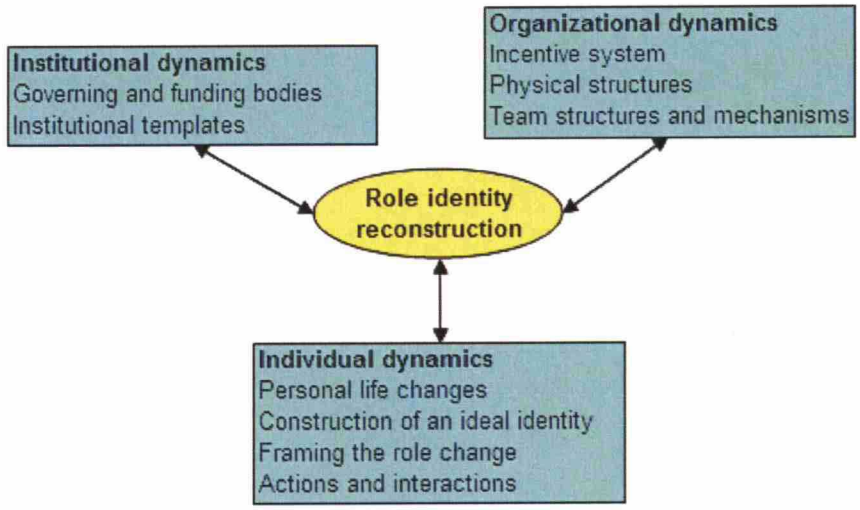

Figure 1. Framework for reconstruction of professional role identity (modified from Chreim et al., 2007)

Institutional dynamics

Governing and funding bodies

The different providers and institutions that govern medical professions practices. Especially government and professional associations set up and strengthen institutional constraints that influence on the behaviours of health care experts. A change in the role of one professional group will probably strongly impact to another group, which may be incapable alone to defend or to resist the change. (Luke & Walston, 2003)

Institutional templates

Professionals in changing environment encounter the difficulty of dealing with the traditional role, of how the person is expected to act, and the emerging role, of how they see themselves behaving in alternative situation. As Chreim et al. (2007) discovered that although physicians could act according to traditional role template or adopt evolving role template, they were

constrained by templates perceived legitimate at an institutional level. The question is, they continue, how experts deal with the tension deriving from these.

Organizational dynamics

Incentive system

A change in compensation can promote medical professionals to alter their practices and to co-operate in multidisciplinary teams. (Denis et al., 1999). Chreim et al. (2007) continue that general criticism towards current payment system and thus the urge to explore alternative payment methods and the willingness of governing and funding bodies to support the change are vital to successful role change.

Physical structures, e.g. information systems, physical team and person location

Hatch & Cuncliffe (2006) argue that visible marking of group boundaries has a strong influence on group identity within organizations. They can even remove physical boundaries between multidisciplinary groups and allow interaction, strengthen trust and enhance collaboration (Chreim et al., 2007).

Team structures and mechanisms

As Abbott (1988) already argued, professional groups frequently attain power by pulling it off from competing groups. The richness of struggles over professional demands may complicate the role change, where different groups focus on boundary negotiations (Chreim et al., 2007).

Individual dynamics

Personal life changes and search for more satisfactory roles

Pratt et al (2006) argued that younger physicians at their initial stage of professional career have little discretion in reshaping their work roles, and continued that by gaining more discretion it would provide role changes. Chreim et al. (2007) continue that also other factors outside achieved working experience, e.g. life experiences and maturity, would promote transition.

Construction of an ideal identity

Professionals in role transition phase who are able detect role models can identify prospective identities and collect set of instruments of tacit knowledge, experiences and opinions which they can use in restructuring to a new role (Ibarra, 1999). Triggers to seek alternatives and thus weigh current role may result from disappointments and external and internal changes (Ashforth, 2001).

Framing the role change

Experts may find it difficult to adapt new role methods but also to give up fragments of their old roles. Thus it is important to have continuity in some aspects of role identity and promoted change in other parts of identity and framing enables foundation of continuation (Chreim, 2002).

Actions and interactions

In order to enable the role change, actions and interactions among multidisciplinary professionals are obliged: common visualisation of control and content of role change are vital, the trust needs to be built and the role set adopted. (Chreim et al., 2007)

3 RESEARCH METHODOLOGY AND DATA COLLECTION

From traditional aspect normative theories have been commonly in use among accounting research. During the turn of 1970s the demand for explanatory perspective gained attention. These positive theories don't provide guidance directly but they help researcher to understand the variables attached to the decision and the reality behind them. Positive research aims to anticipate and explain the examined object in its actual context. Normative research vice versa aims to provide guidance of how things should be done. (Scapens, 1990)

Neoclassical economics has attempted to explain behaviour on macro level and it isn't applicable to explain the hypotheses of a single decision-maker or group's behavioural models. Central principles in it are rationality of decision making and utility maximizing. Neoclassical theory assumptions are also provided for a basis of management accounting research, but the suitability can be questioned due to macro perspective. Thus in explaining process of individual behaviour, a common situation in management accounting, and the limits of the theory can be come across. (Scapens, 1990)

Due to the limitations of normative and positive accounting research the popularity of on social theories based case studies have grown. They don't aim for a wide generalizability but to recognise social rules and routines representing certain culture. In this context the essence of social theories is that accounting is socially constructed event. Accounting can thus be seen as a language which evolves from the organization and is a result from the actions of organization (Ryan et al., 2002). Case method enables the analysis of management accounting in its context and is effective in situations where the object is not completely familiar, the features are complex thus possibly corrupting the results (Ferreira & Merchant, 1992). Also case studies are suitable for studying accounting as a batch of collective social system. (Scapens, 1990)

Former field of management accounting case studies has been grouped in various ways e.g. the relation between research and theory and the empirical intervention of the researcher (Keating, 1995). Scapens (1990) approached case studies by dividing them into five categories:

- Descriptive case studies
- Illustrative case studies
- Experimental case studies
- Exploratory case studies
- Explanatory case studies

When considering current research, features from multiple study types can be attained. From the role perspective explanatory research is dominant because it aims to examine certain reasons behind detected behaviours with help of current theory. On the other hand when approach from adaptation perspective, exploratory type research features can be notices due to the examination of the facts behind new phenomenon, hybridization.

The research method of case study was chosen because suits the best to the aims of this research. Traditional research methods aren't adequate enough to understand the management accounting phenomenon in contemporary organizations under the constant fluctuation (Bruns & Kaplan, 1987). This research in some extend is constructed to test the boundaries of the theories in hybridization. By using case methods it is possible to provide interesting and rich stories of constructions of accounting information (Hopwood, 1983).

Bruns & Kaplan (1987) argued that there are significant benefits in using case study methods. First, they provide a basis other research areas as modelling. Secondly, while organizations and management are constantly regenerated, adapting in different environments, it is vital to the academic research to keep up with the development and avoid being fallen behind. Thirdly, case study methods can assist on teaching the practices of actual organizations. Reality is far more complex than simplified models used in universities.

3.1 Reservations concerning the study

3.1.1 Generalizability of the results

Although there has been an increased interest towards case method usage in management accounting research, also criticism has been announced. The arguments have considered the inaccuracy of the method and the lack of generalizability, which in statistical methods are perceived to be better. The criticism towards generalizability has been based on the social context and institutional dynamics, but it isn't appropriate to widen the scale to response the behaviours of a large population. Case studies are useful in generating hypotheses, to develop theory, which can be tested by statistical methods (Scapens, 1990). Accordingly, their generalizability is greater than commonly is expected. (Lukka & Kasanen, 1995)

The main challenge in generalizing case studies is the small amount of research objects. Despite the reservations, some researchers argue for high quality case studies being well generalizable, others even question the intention to aim for it. However, all accounting studies share the same prerequisites for generalizability. Theoretical knowledge covering the research area, prior and current research's results are the basis for generalization. (Lukka & Kasanen, 1995)

3.1.2 Validity and reliability

Because evaluation criteria have been design for measuring quantitative researches, it is rather challenging to evaluate validity and reliability in qualitative research. Some have even arrived at an understanding that these cannot be even evaluated in qualitative studies. Regardless, criteria reminding validity and reliability ought to be considered in order to fulfill the demands for scientific accuracy. That can be achieved by examining how the description of research object and the interpretations are in line. (Hirsjärvi et al., 2004)

Validity refers to is the researcher studying the phenomenon the person ought to be examining. It deteriorates if the research is either designed or conducted so that the researcher unintentionally examines other than intended phenomenon. The essence of reliability is that whether the

researcher is obtaining data on which the person can draw on. Reliability deteriorates if the data isn't independent of the circumstances under which they were gathered. (McKinnon, 1988)

There are many threats to validity and reliability, which McKinnon (1988) has divided into four categories:

- Observer-caused effects
- Observer bias
- Data access limitations
- Complexities and limitations of the human mind

Criticism of case study method considers the reactions created by researcher's physical presence. Thus the situation available for researcher's interpretation isn't normal, but modified for the observer. Correspondingly, observer bias can be characterized as the "tendency to observe the phenomenon in a matter that differs from the 'true' observation in some consistent fashion". Researcher's selective perception and interpretation can distort the results. (McKinnon, 1988)

Data access limitations arise from two main factors. Firstly, the researcher can only observe the short situation the person is on site, not events before and after the time period. Secondly, the target can limit the data access. The last category, complexities and limitations of the human mind provoke two types of validity and reliability threats. Firstly, the target can aim to deceive the researcher. Secondly, subject's announcements might be influenced by natural human tendencies and fallibilities. (McKinnon, 1988)

Above mentioned threats can be controlled by several strategies and tactics. These are, e.g. using an appropriate amount of time in preparation, using multiple research methods and the adequate behavior of the researcher. (McKinnon, 1988).

3.2 REALIZATION OF THE STUDY

The empirical data for this study was gathered through interviews. By collecting the data face to face validity and reliability can be better evaluated when compared to survey methods (McKinnon, 1988). However the main advantage is the flexibility. The researcher can fluently react to occurred circumstances and thus ensure more possibilities for interpretation of results. On the other hand, interviews are relatively time consuming and they demand both good preparation and advance consideration. (Hirsjärvi et al., 2004)

For this study seven semi-structured interviews was arranged. Some have argued that in these events same questions ought to be asked for every interviewee and also in same order. Others emphasize the possibility to alter the order however no commonly accepted definition for conducting semi-structured interviews has been made (Hirsjärvi et al., 2004). Themes for the interviews were prepared in advance and discussed with the interviewees but they didn't receive accurate format of how the events would be examined. Thus the researches enjoyed the freedom of directing the conversation towards appropriate direction.

There were six clinicians and one from accounting department chosen to this study. They all were in mid or late career phase. Younger professionals were excluded because the aim was to observe the perspectives from role identity reconstruction. Four of the interviewees represented nursing line, two physicians and one controller was chosen to give valuable information on the cooperation between professions.

4 CASE EMPIRIA

4.1 DESCRIPTION OF CASE ORGANIZATION

The empirical analysis of this study focuses on the Department of Psychiatry of Helsinki University Central Hospital (HUCH) Hospital District. In Finland specialised medical care is divided into 20 hospital districts of which five are university hospital districts. Largest of them is the Hospital District of Helsinki and Uusimaa (HUS), which has five hospital areas: HUCH Hospital Area and the Hospital Areas of Hyvinkää, Lohja, Länsi-Uusimaa and Porvoo. HUS operates in province of Uusimaa in 24 hospitals and together with the largest university hospital in Finland, HUCH it offers treatment on all of the major components of special medical care including e.g.: surgery, medicine, anaesthesiology and psychiatry. (HUS annual report 2006)

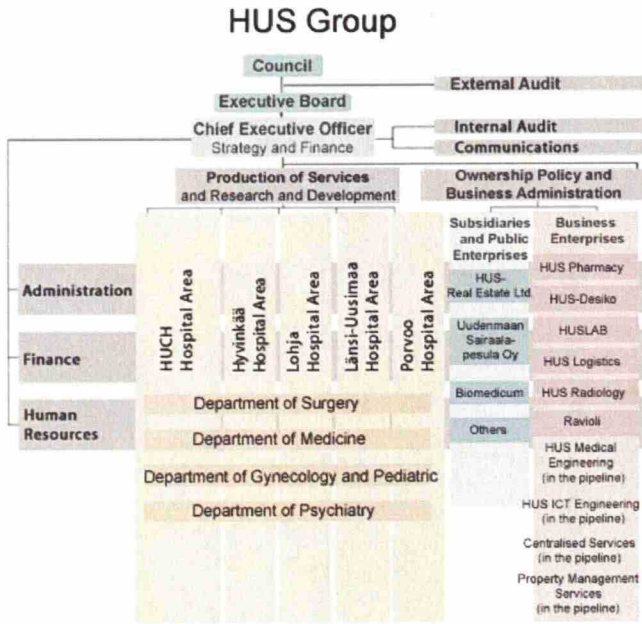

Figure 2. HUS Group's organizational chart (source: www.hus.fi)

In financial year 2007 HUS's operating income was 1404 million Euros and expenses 1320 million Euros. HUS covered a population of nearly 1.5 million and over 440 000 different persons used the services during 2007. The Hospital District offered almost 500 000 hospital stays, 295 000 bed days, 1 500 000 outpatient visits and 86 000 surgical visits. Majority of these occurred HUCH Hospital Area (400 000 hospital stays, 1 100 000 outpatient visits). In 2007 HUS employed around 22 000 clinicians from which 12 000 were nurses and 2 500 physicians. (HUS annual report 2007)

New millennium has been an era of organizational changes. HUS Hospital district was born in 2000 when two hospital districts were merged. At the same time HUCH was transferred as a part of it forming a new hospital district, HUCH Hospital District. In 2002 Jorvi and Peijas hospitals were attached into HUCH Hospital District. The Department of Psychiatry has followed these steps. In HUS-birth former Hesperia Hospital was attached under the management of HUCH Hospital District and was renamed as Psychiatrycenter. Administrative responsibility of Jorvi's and Peijas' psychiatric treatment was gained in 2002 and in 2004 a new Neuropsychiatry clinic was established. (Joutsivuo & Laakso, 2008)

Special feature in Finnish public health care sector is the linkage into municipalities. After Public Management reforms municipalities were given the administrative authority. Public health providers became thus the leaders of hospitals and hospital districts, but remained also as customers. HUS e.g. is a provider of health service to its municipalities, who buy the services but also own and govern the HUS. Also the role of CEO was emphasized by directing more responsibilities to the position. A step towards business life was taken in order to gain functional managership. (Joutsivuo & Laakso, 2008)

HUS, double the size of former HUCH, was expected to remove problems within specialized medical care i.e. the lack of orderliness and inner competition. Although the agreements with municipalities were unfavourable for HUS and buyers felt the services were too expensive. More challenges were brought by the law of treatment guarantee. (Joutsivuo & Laakso, 2008)

In 2007 new CEO, Kari Nenonen for HUS was selected (HUS annual report 2007). Together with newly-organized group's management team Mr. Nenonen started a strategy restructuring process which aims for the direction shown by municipality-owners: new management system is implemented and finance is emphasized even as a key value of the organization.

4.2 Framing the role identity reconstruction

Clinicians interviewed were all involved with administrative tasks. When asked about the changes in their work, they responded the same way: administrative tasks took more of their time than before. They had altered their duties from day-to-day patient treatment towards coordination. Clinicians felt a clear transition in their tasks, which was seen continual as was expressed:

> *"Yes, towards this I have come. Of my own volition or not, my career has brought me to this position. And this process seems to continue...from this point on we are facing a really active organizational change, where I'm centrally involved."* (Chief Medical Officer A)

These factors behind the role change are examined next from three perspectives: institutional, organizational and individual.

4.2.1 Institutional dynamics

Governing and funding bodies

> *"More than business life, this may remind of representative democracy. The responsibility comes through this way that I answer to representative organs for the propriety of this activity."*(Chief Medical Officer A)

The role of a clinician is bound in a relationship web, where multiple factors direct their actions. State doesn't anymore provide capital for public health care sector but municipalities have agreed of guaranteeing their occupants' health services. HUS is an association created and owned by municipalities together to provide special health care. Local government regional authority has the controlling power over HUS. So they create the boundaries in which Hospital Districts should act and coordinate their actions. As is illustrated below, different departments have directed obligation to plan their cost base, but are incapable of influencing the revenue side.

> *"It is in a way, it is my job, in some form primarily, that within the limits of given commands we can produce something...nobody else than we here know, how psychiatry ought to be organised. So that we would have planning and legitimacy here, but frames come from there, above."* (Chief Medical Officer A)

The society's demand for profit responsibility has influenced the municipalities to shake the conservative attitudes among clinicians: the money shouldn't be taken as guaranteed rather it should be gained. They wanted clinicians to understand the scarcity of resources and thus direct the supervision of the actions to the instance who knows them best, clinicians.

> *"Towards this whole operation is directed a critical pressure; that is everything beneficial and in what direction should we aim. And this service structure reform has been a large political agenda for already a while. When population is aging, especially the institutional care for senior citizens...it seems like that there is a threat for the capacity of controlling all of these. It directs to this pressure that are we using our resources correctly."*(Chief Medical Officer A)

Municipalities have put pressure on hospital districts also on self-valuation of what actions are effective. Thus they emphasize that the treatment done in hospitals can be measured, not only from cost-aware perspective but impressiveness perspective. The treatment chosen should be considered of how it improves the patient's life.

"And this way of thinking, as emphasizing the effectiveness and approving it, has signified in our system a lot. That former this wasn't demanded, physicians were allowed to act as they wanted, to focus where they were trained to, what was nice, good. Currently it is asked for more and more evidence of what we are doing is smart job and that it is useful. (Chief Medical Officer A)

What makes public health care sector so special is the dual role of the municipalities. They are the owner and the customer at the same time. In a business life situation, where a company needs to act if operating expenses have risen, one solution is to increase prices. In public health care, hospitals are bound with the agreements made with the municipalities. The story below illustrates the lack of authority when certain actions would be needed.

"We have given frames within we have to act. And our municipal demand is like this, so we have to adapt. So we cannot increase prices accordingly. When we moved e.g. here, our rents doubled...so you can imagine that it couldn't be directed to prices. It had the impact that we are even currently in a deficit situation. Now that we would add some in prices, we were told not to do so because it hasn't been agreed (with municipalities). Even though we do a deficit budget, we have to make to zero level. Thus again in present year our system indicates that we exceed our budget in some units. (Controller E)

From one unit's perspective the situation was seen frustrating. They have received positive feedback from Helsinki that the municipality is willing to buy more of unit's services, but at the same time they couldn't get more resources to answer the need. The unit saw themselves between the client (and also the owner) and their own central administration. They couldn't exercise any authority in directing their supply of services and, as below is demonstrated; they experienced themselves as a method of politicking

"The demand is much higher than our supply, but then from central administration is mentioned that resources cannot be increased because we have to stay in our budget...that what might be the idea behind that. I know that here are units on which municipalities aren't so keen. The city of Helsinki argues that it doesn't want to pay for patient duties in

HUCH. But they have directly said to us e.g. from the government of Helsinki that they are willing to buy more of our services. But we cannot sell them, because we don't have sufficient resources and cannot go over the budget. This is a sort of...I'm no economist, but I think this is a bit of inconceivable formula." (Associate Chief Medical Officer B)

Institutional templates

Earlier in HUS history manager roles were pointed to doctors on a basis of their academic research. Their focus has been on clinical work, not on their managerial skills and that has gained attention. Pressures from municipalities have initiated a trend towards emphasizing orderliness and leadership. As was presented in theory, professionals in changing environment encounter the difficulty of dealing with the traditional role, of how the person is expected to act, and the emerging role, of how they see themselves behaving in alternative situation. In HUS historically leaders were clinicians, now business oriented thinking was wanted.

"At the moment here at HUS where I work is an ongoing organizational restructuring process towards leadership where professional leadership has been implemented as a general principle i.e. that being a doctor is not automatically a synonym for being a leader...that is a trend of this time. Regardless to this profession is connected so much care-oriented responsibility, people deserve right treatment...so that at least on my level we need a physician in executive role. I consider myself as an executive physician." (Chief Medical Officer A)

Clinicians in executive position thus encounter the problem of being a clinician but on the other hand being a leader. As Chreim et al. (2007) argued that although physicians could act according to traditional role template or adopt evolving role template, they were constrained by templates perceived legitimate.

"And those are in this new HUS strategy which has been launched here, which emphasizes certain management training. And this is associated with the same thematic that you have, that undeniably it is a bit problematic that physicians don't have such management knowledge...and this is a theme in our new (strategy), whereto should physicians use this transition. And I believe that the most active of us attempt to keep up with this management knowledge." (Chief Medical Officer A)

4.2.2 Organizational dynamics

Incentive system

There was no evidence found of (monetary) incentives affecting the role change. Interviewees perceived themselves seeking for more responsible positions and challenging tasks, but didn't highlight monetary factors as a motive. The ongoing strategy project was seen more as rearrangement responsibilities, which wouldn't have any effect on salaries.

"There are no economic sanctions included, nobody is getting fired or nobody's salaries are going to be raised. It is just agreed liability distribution that we need to demand certain persons in charge to prepare an explanation of what is done and controlled."(Chief Medical Officer A)

Physical structures

When HUS was founded also new management systems were implemented. The aim was to improve the communication, the commitment of clinicians to financial controllership and transparency. The adaptation process however didn't provide the desired outcome: accounting standards were created on group level and they were not applicable on department level. Thus different instances produced their own calculations which were not comparable.

"Then we received these computer based programs, these MIS's or Management Information Systems here. And we have also diverse statistics in our computers, but what confused me and many others was that the numbers were different for a long time. Where can you count on if one shows this and another this? They tried to make it consistent, but it isn't...I think the numbers are a bit different, depending where you look for the information. I don't know why, I'm not an expert in that field." (Director of Nursing F)

This enforced the unwillingness to adapt new tools. On the other hand though clinicians were obliged to take the system in use, they were not strictly controlled. From the municipality level the demand existed, but the former Chief Medical Officer felt the clinical autonomy so commanding, that the need of acquiring management accounting tools wasn't emphasized.

"The former leader was very good and professional, but he was a so called soft leader that he didn't want to lead by numbers. The attitude was completely different. If we discussed about balances scorecard, he mentioned that it is goofy...that the scorecards don't play any role. This sort of a management by results didn't fit to his frames at all." (Controller E)

These led to a situation where the ones who were keen into measure their actions invested their time and effort to learn new systems, others purely ignored them. Finally the licences were even taken away from the ones who hadn't used those.

"In previous phase everybody had an idea that the implemented MISs weren't widely in use. Thus we took the licences away or shut them down, when they weren't obtained. When a person doesn't visit the program in a century, it is futile to pay for the license." (Controller E)

Not surprisingly the department (and also whole group) struggle currently with the same problems. Clinicians have not been demanded the adaptation of management system, thus there were no active feedback mechanism operating so that these management systems could have been made more user-friendly. Thus the mechanism is still time-consuming as is illustrated below:

"But we do have these...I don't know about financial administration, but the brand new patient management system is totally primitive. It is shocking that when you calculate treatment times and flow-through statistics it has to be made by pen and paper, when it is impossible to get it out from MISs. This is something from the 70s. It means that every time that we follow these ones a year, we have to detach some chancery officer for several days to check these with paper and pen. It is pure madness!" (Associate Chief Medical Officer B)

At the beginning of 2008 a new management team started working at the Psychiatric Department. Along with the new HUS strategy work they have emphasized the importance of consciousness. They believe that if clinicians would understand the impacts of their actions correctly, that if something needs to be improved one should start the change from looking in the mirror, then the attitudes will change. One part of the process is to make the management systems user-friendly.

"So that we emphasize the level of awareness. Even I have said it many times, but however we don't have sufficient reports, where one could get the information easily, not by hard work, but quickly. And that we would have ready reports which we wouldn't need to do ourselves, because it is needless for clinicians to spend their time on those, which we cannot do accurately. Then the resistance would ease, when you could easily click own unit's reports open and those would be on-time and readable. This can be considered from business point of view, that is it so, and it so that we don't have the reports available. I hope that in a couple of years we have, when new CFO has been chosen and we have developed financial reporting programs and their feasibility." (Leading Director of Nursing C)

Challenges arise, besides among clinicians, but also from accounting department. From their perspective different units in the Psychiatric Department have the access to management systems and thus they should be getting the information.

"On the other hand I have been thinking about that is there something wrong with us...they can in unit level, even on every ward look monthly performance reports and print them out from the system. They should control it. I would thought, that when we have normally small wards, they could observe what is done in-house." (Controller E)

One reason for the challenges is the resource problem in accounting department. They have the knowledge of creating the needed information at unit level, but they have been over-employed so they haven't had the time to focus on supplementary tasks, as providing unit level information. Only recently there have been changes, which have had positive impact.

"...and at this moment we have received, thank God, a new person while another (controller) will retire. The person has done many reports and that has been a factor for which we haven't got time, to do unit level reports. Since our information systems don't give us entirely ready, solid report. Now we have done the first which has been handed out to units." (Controller E)

Also physical distance between accounting department and separate units has delayed the implementation. Department's management work in the same building as accounting people and from their perspective the system operates well. They can get the support they need.

"Well, we do have here in the same corridor, that one can drop by and ask or I can send e-mail. Then we have accounting personnel in management group, even two. That advantage we have here. This Helsinki (hospital) is in my opinion better managed although we were said that Jorvi (hospital) had organised their finance well. As in a way was, but much more invisibly. Here the persons are physically closer, so that you can go and ask how much money you have left." (Director of Nursing F)

And as the Controller continues, the accounting department and clinicians have a good, operating relationship.

Well, I would say that you can call or come in or...at least from my perspective so. Even I do know this people. So in my opinion, nobody should have barriers to approach." (Controller E)

But from separate unit's perspective the situation is different. They experience that their communication with accounting staff is complicated by the fact that they are located somewhere else.

"Certainly particularly if they would be here on the spot, that would be an ideal situation. Really, then we could communicate face to face among people, even I think it would be wonderful to go and ask for arguments and information personally. That would be awesome, only I don't know how realistic that is. I do experience that somewhere damn far are the accounting things and fortunately I haven't had to do these tasks." (Senior Ward Sister D)

As Hatch & Cuncliffe (2006) argued that visible marking of group boundaries has a strong influence on group identity within organizations. Discovered evidence supports this ideology. In current case the result was negative attitudes towards implementation of new management tools. Clinicians were frustrated because they couldn't get access to desired information or it demanded too much effort. Thus they could justify their actions not adapting management tools collectively.

Team structures and mechanisms

Abbott (1988) argued that professional groups frequently attain power by pulling it off from competing groups. At HUS there has been historically strong duality between physicians and nurses. The organization has lines for both groups in which they report and interact. That has had the effect of creating boundaries between professionals: nurses and doctors have their own chains from operational employees, through administrative personnel to own labour organizations. Thus the groups have different focus areas. When physicians are concentrated on

clinical aspect, nurses have more administrative perspective. That has also been emphasized in their education.

> *"I can't say...it might be, I wouldn't want to accuse our physicians...it is but so that it is more unfamiliar for them to think in this way. It takes more for them to learn. All of the Directors of Nursing under my subordination have strongly through their studies...so their starting level is different. If compared to their companion executive physicians, who are at the head of the responsibility area, this aspect is not supported in their education."* (Leading Director of Nursing C)

The perspective difference has led into a situation, where nurses are more aware of financial figures. They have been more flexible on acquiring new tools than physicians. Historically Directors of Nursing and Senior Ward Sisters have had the obligation to be involved into administrative tasks, thus the step towards accounting was not seen offensive.

> *"I do believe that the management of nursing in Director of Nursing level, who have 150 employees and then on ward sister level, who have 10-30 employees, do understand the impacts of finance and know how to think of what kind of an influence would a new employee or purchase have on finance. And if it is empty in hospital, it has a straight impact on hospital level. Physicians don't necessarily consider this from same perspective."* (Leading Director of Nursing C)

This difference in ways of thinking has had the influence on creating a gap between the two professional groups. The result was even culminated on doubts towards the eagerness of clinicians to accept management accounting tools, i.e. management by results ideology.

> *"So physicians are here even more clammy and don't care for such a things like finance, not at all. It jus happens to be so, psychiatric side even especially, that there not many persons who would be interested of these things. That they would care. Of course Senior Medical Officers absolutely have to take the responsibility because of their position. But I don't think that any others would do."* (Senior Ward Sister D)

One reason for the existing duality is the differences in education. Physicians are focused on patient treatment, on their clinical role where administrative perspective is non-existing. As is illustrated below, doctors' career path is concentrated on their academic results where on nursery side there is also master level education purely on administrative perspective.

> *"Yes, yes. Here might be some sort of a difference of what is experienced in physician side, when I represent here after all the management of nursing. I already received comprehension of general management that from my basic education. Those things aren't detached. Physicians however make a clinical career and are directed in it, where they advance through academic demonstration. Management tasks come along this scientific research. Thus they have completely different aspect accentuating clinical perspective, not the administrative duties."* (Leading Director of Nursing C)

Other explaining reason is the power relationships. Normally in high management positions, meaning tasks in group management, are mainly doctors who have their own profession's perspective. Thus the persons who have the power of making extensive decisions have been clinicians, usually physicians, who may not have the needed management skills. And that have had negatively impacted the cooperation between nurses and doctors.

> *"Yes, maybe more aware, not perhaps highly competent. We may have less authority because in leading positions the power to decide is given to physicians. It is traditional here in hospital organizations, although we hope it to change so that we would have professional executives or like that, who would understand our chain. Anyway there are a lot of counter forces who build upon that only physicians can lead a hospital. And it is of course claimed that everybody should do the tasks in which they are at their best. Thus physicians could concentrate more on their core competence and developing it."* (Leading Director of Nursing C)

As was examined above, the physical distance between separate units and accounting personnel have had negative impact on acquiring management accounting tools, also evidence from the

team structure perspective was found. When asked their current cooperation with accounting department, the answer was judgmental:

> *No, nothing, no. As I said earlier, it would be interesting to know when we have earned our salaries and what follow-up actions should be done. We don't have any idea of these. We don't have any direct or indirect influence with financial administration. It is just arguing about computers, but not like...in any form, in substance or servicing improvement form, no."* (Associate Chief Medical Officer B)

Thus there could be noticed duality between doctors and nurses, but also between accounting personnel and clinicians. If the different occupational groups are not actively in contact, the question rises, how they can create trust between them and through that an operational entity? These are the points that the new management team on their to do -list during the ongoing strategy renewal project, to enhance cross-border communication.

As Chreim et al. (2007) indicated the richness of struggles over professional demands may complicate the role change, where different groups focus on boundary negotiations. Strong evidence was found on cross-professional disputes and on legitimated resistance thus delaying the role change.

4.2.3 Individual dynamics

Personal life changes and search for more satisfactory roles

As was illustrated above, clinicians didn't describe monetary incentives affecting their role change rather the search for more responsible and challenging tasks. When gaining more experience the possibility to influence on surroundings was seen important.

"Surely everybody on their own career, I think, are looking for responsibility...we have an administrative need of control as our basic need. We tend to ask for the devotion, that can I decide for this, can I adjust this...at least I recognise it from myself." (Chief Medical Officer A)

Other motives were described as challenging oneself to be confronted with the unknown. The key motive was seen that effective learning would be found beyond their comfortable-zone. Thus it was described as a sort of an adventure seeking.

"But then on a direction level I feel that surely experiencing the unknown might be the thing...that in a way you know, that there is something out there that I haven't examined, thus aiming to that direction." (Chief Medical Officer A)

Perhaps surprisingly and supporting the strong clinician identity, only one of the interviewees stated administrative tasks as the person's goal. Here, the person also emphasized the importance to understand widely the consequences of ones actions, thus administrative position would be natural continuation.

"Well, it has been a lengthy goal and destination for me to aim for administration. That pretty rapidly, that first graduating as nurse and then applied for administrative education. So it has been a goal of mine." (Leading Director of Nursing C)

The most common answer was that they were descended into current positions. They all experienced themselves strongly as clinicians, but were neutral towards change in their roles. They accepted the forthcoming as given and tried to modify their thoughts in new situation.

"It has drifted. I didn't have anything against it what has come across. They have been quite interesting, but then I have noticed that my tasks are completely on this side..." (Senior Ward Sister D)

Physicians experienced the change as more pronounced. They were more concerned about their clinical autonomy, and were frightened of how administrative tasks would impact the quality of their treatment. They expressed more clearly their desire whether to stay in patient work or be directed towards administrative tasks.

> *"It is a good question...I'm not a management clinician; I've never wanted to be one. I don't want to be loosening from patient treatment or research, purely from personal reasons. But administration in a way, that developing patient treatment cycles and directing caring performance reports upwards and these kinds of. In that way like Chief Medical Officer A, I'm not an administrative person."* (Associate Chief Medical Officer B)

Construction of an ideal identity

Ibarra (1999) argued that professionals in role transition phase who are able detect role models can identify prospective identities and collect set of instruments of tacit knowledge, experiences and opinions which they can use in restructuring to a new role. In current case many of the interviewees mentioned the importance of further training at work place. They emphasized that arranged education had a positive impact in understanding the results of personal actions. Thus by joining those training sessions they were able to broaden their views.

> *"Hmm, started...yeah, what has been the driving factor, that I have started to think more of quality. One at least is, that I have went through quality educations her in HUS. Yes, education, information brings more it, as if thinking between the ears. Now, that you mentioned it, it must be also, that I've started to consider, how we can produce better with the personnel at hand. Thus it may have been also hided learning."* (Director of Nursing F)

Another example was external models. Some of the interviewees had worked in different organizations with varying organizational behaviours. These examples were seen encouraging and had a positive impact on interviewed clinicians. They felt that they were more aware of the consequences of their actions when they could exploit financial figures.

"I was a while working at Karolinska hospital in Stockholm and there we had a completely different administrative model. I did the same tasks there, but we had financial responsibility and a grant directly from management group. We were obliged to examine this many patient during the calendar year so that we would earn our salaries. How you do that, is completely your own decision...you can examine more and then you'll receive more money. So that this is the minimum frame. That did have a really short linkage to own monthly salary." (Associate Chief Medical Officer B)

And as the Director of Nursing continues, by understanding the consequences of their actions the work itself becomes more motivating. Thus it was possible to have an impact of how things are done, to experience the power of authority.

"I could give you as comparison information from Pirkanmaa where I have come. There we had this much more intensively in our hands, that there even on ward sister level we controlled financial figures monthly, even in last decade. And we lived pedantically. I experienced it positive, that in ward sister level they knew where we were. That if we are out of toilet paper money, and then we considered what we would do. Then it was more concrete." (Director of Nursing F)

Framing the role change

Experts may find it difficult to adapt new role methods but also to give up fragments of their old roles. As was above illustrated, clinicians have felt anxiety towards the integration of management accounting as a part of their duties. The feedback describes how clinicians were frightened by the fact that they would have to change their identity rapidly and that the change would have a negative impact on patient treatment. Although the last 8 years in HUS have been an era of constant renewal (and an effort towards implementing profit responsibility), there is still currently suspiciousness against finance.

"Well, maybe from there comes something like, our values has been hardened and that finance are put in first place and...a certain fear of, is our patient treatment going to suffer,

that the time of caring will be shorter and we aren't able to give as good treatment than we were used to. In a way, some kind of anxiety." (Leading Director of Nursing C)

All of the interviewees emphasized the importance of superiors taking the lead. The Department of Psychiatry's former executive was strongly focusing on the clinical aspect when directing the organization. Thus clinicians weren't encouraged to implement management accounting knowledge as a part of their work, even in senior positions. Now the new executive has gathered administrative persons together to learn and develop the Department's operation.

"And now our new leader of the Department has wanted to be involved. And he has insisted of committing us, deputy directors into that we look together the finance and planning. Former we didn't, e.g. on last year, have that anybody else than our controller would have followed the development. It has been outsourced widely from behalf of acting management." (Leading Director of Nursing C)

That has had a positive impact on reshaping the images of how clinicians encounter accounting. Senior clinicians have seen the implementation process extending their knowledge of how different factors influence their work and thus helping them to become more motivated.

"Majority of them, who are in a certain restrictive role, are motivated to the tasks and are looking for comprehensive conception of where we are going...such a healthy, realistic picture, that they are not disconnected factors, money and the improvement of our activities. Rather they are interrelated. We don't have to know everything so intensively as our controllers, but that would somehow understand what the impacts of our actions into the finance are and that we do have an influence on it. That is how much we want to know about it, in a way of understanding." (Leading Director of Nursing C)

What was seen crucial enabling factor was the motivation on an individual level. Without the willingness to seek alternative working methods, the change is unlikely.

"I'm interested in it on a personal level, or that I've always wanted to be aware of the finance. In a way through municipal finance, that we function on tax payers money. Thus we should have a certain cost efficiency or effectiveness. We cannot take a general attitude." (Leading Director of Nursing C)

Actions and interactions

As Chreim et el. (2007) argued, in order to enable the role change, actions and interactions among multidisciplinary professionals are obliged. Historically in the Department and in HUS there have been role battles between nurses and physicians. Also the role of accounting has been seen only as secondary information provider. These have led into a situation, where attitudes have changed. Like Chief Medical Officer describes the attitudes towards ongoing strategy renewal project:

"In this phase I still believe and as I hear it from this house, that many are ready and maybe now it is suitable time for reconstruct this organization towards new direction. Maybe this organization has been a bit traditional, hierarchical so far. Thus it is a good moment of activating it a bit." (Chief Medical Officer A)

On senior clinician level it was seen important that they would have something on what they could ground their actions. They perceived that accounting assisted them to justify what needs to be done. The change was seen encouraging, because earlier they were not able to have any quantifiable factors supporting their opinions and thus weakening their credibility.

"Because we cannot purely look at the treatment days, since we give assistance to others, that patient wouldn't come here for more expensive treatment. In a sense that we would understand the figures and be familiar with them, of where they come from and then start to explain our own actions. Neither to first explain our actions, that we have so difficult times. It is impermanent currently to have explanations without facts. You need to have the facts first and then explain if needed. Our new leader of the Department controls our financial performance more than the former. It challenges us to have figures on the basis of

our negotiation situations, not giving essay form answers." (Leading Director of Nursing C)

From a more general perspective it was seen important, that everybody would understand the reasons for renewals – that strategy project was started for a reason. The goal is to direct the authority towards separate Departments and even to unit level. As the Director of Nursing describes the ongoing process, by cooperating the goal, proactively, would be achieved.

"Now we have agreed, that when we are already measuring employees performance, we have started to go through the numbers with staff in one of our units. We share the opinion of that it promotes our visibility. That kind of visibility and openness should be encouraged and directed towards the clinical employee at line level. So that this would be our common, shared opinion. Thus we could achieve the desired proactivity. Finance is not a matter of only the management, rather everybody's." (Director of Nursing G)

4.3 Becoming hybridized profession

"Efficiency and productivity has been here in psychiatry a curse word." (Controller E)

Encounters of professions within the system can evolve in hybridization or as well in competition. As Kurunmäki (2004) argued, a key role is played by how lateral information flow and discrete technique mobility among professions are organized. This chapter describes how clinicians perceive themselves and illustrates their current attitudes towards accounting. Also the evidence from polarization is illustrated. The chapter ends in examination of the adaptation process.

4.3.1 Self-concepts of medical professionals

Interviewees were more or less in an administrative position. They had altered their routine tasks from patient treatment towards management tasks. Thus it was important to examine their perspectives of themselves – would they describe their role more as a clinician or an administrative person. The below citation illustrates also the basic ideology in public hospital: academic eligibility directs towards management positions.

> *"It is extremely important question when considering the identity inside the profession, and when I approach it from a general perspective being as old as I am and in this phase of education, is really my identity more of physician or executive physician then the answer is executive physician. It is a synthesis where I have ended up. I have strongly been physician and psychiatrist as my identity and researched these contents and disruptions, but it has qualified me at the same time. It is a feature of this profession that the qualification of meanings and sciences lead towards more responsible positions and brings thus more administrative tasks."* (Chief Medical Officer A)

The development process was seen also problematic. Every interviewee emphasized their clinical identity on what they form their current self-image. Most of them missed the patient work, which was seen as the major drawback after gaining more administrative tasks.

> *"It is such a conflict. This has just gone...this position is what it is. I would much rather be a clinical person from my basic character and anyway, definitely, definitely! But these tasks have purely drifted automatically because of this position. Suddenly I've noticed that in two years I haven't had the time for have my own patient. The closest to my heart is patient treatment, but time is something that I haven't got."* (Senior Ward Sister D)

However clinicians felt that administrative tasks had extended their perspective on patient treatment. They saw that the clinical identity still existed in the background, but they could now observe patient treatment in wider scale. Thus patient treatment was no longer seen as purely the contact with the individual but as a combination of resources, as below is illustrated:

"Of course I'm the administrative person, but the clinical aspect hasn't gone anywhere. I'll always have the patient there, but I'll have to consider here the patient from this angle and the personnel around it. Anyway for the best interest of the patient we are acting considering the methods I can afford and can use, what it is justified to emphasize." (Director of Nursing G)

Though there was evidence of clinicians who argued purely for changing their current identity towards administrative identity.

"Well, I've been both so far, but I hope that more as a administrative person in future. So I have educated myself, it was the administrative line which I went through when I received my Masters degree. And it has been closer to my heart." (Director of Nursing F)

Motivation to change role

The clinicians had become more aware of the abilities what financial awareness would bring. They expressed their volition to understand how resources could have been managed. Even the most conservative opinion showed positive attitude towards implementing financial knowledge as a part of their know-how.

"I mean that a certain financial awareness of one's own work is a positive thing, where we should be aiming. And that we would receive more feedback from the development and would have more of bidirectional communication of finance. But it doesn't mean that I would need to be a profession in financial calculations, or that I would spend an enormous amount of my time for it. It is just one background variable of which we should be more aware than we are currently." (Associate Chief Medical Officer B)

The current situation was seen frustrating, because on unit level they aren't aware of how their operation's advance. They did receive information of how many patients visited the clinic, but no cost base calculations were available except for the whole department.

"We never receive any unit level information of financial indicators. By that I mean, that have we earned our salaries, earned awful amount of money to the group or are we just an item of expenditure." (Associate Chief Medical Officer B)

This unconsciousness of their own performance was seen as a limitation for they were obliged to budget forthcoming years. As above was illustrated that the conservative side perceived their roles not to become professionals in financial calculations rather than understanding how they could use and plan the scarce resources that they had in use.

"Even if medical treatment will never be directly comparable to normal entrepreneurship, bringing forward the element of the aspects of it would hurt us. I mean this in the perspective of optimizing resources." (Associate Chief Medical Officer B)

Although interviewees expressed their enthusiasm to acquire management accounting knowledge, they expressed anxiety towards their role diverging from patient treatment. They all had strong clinical identity and thus the transition to administrative position seemed distant.

"Well in a matter of fact, it has been agony of abandoning. It was really rewarding, the patient treatment. Now I have had to learn away from it. For me, at least, it has so and it seems like it has been the same for many others. To loosen into administrative tasks has been really difficult. Albeit, there are similarities in them...in the same way you have to care for the personnel. Thus ultimately they aren't that distant, although the perspective is completely different." (Director of Nursing F)

Many of the interviewees rationalized their angst through time consuming. The message given was that if they'd have more time in hand they would use it in patient treatment. Regardless, nobody expressed that they would even had considered turning back into patient treatment.

"No, not in a way that I would manage. No, not besides this job...yesterday I also left from the office after 19 pm. So I don't have the time for it. But for that matter it would be nice." (Director of Nursing F)

Other explanation to these prejudices was that as they were clinicians from their educational background they could evaluate their patient treatment and could thus observe the results of their work. When they evaluated their performance in administrative tasks they encountered difficulties.

"Yes, it has been difficult, yes. The groups are so...compelling that it even hard to describe. It is so nice to be involved. In this administration you cannot see the results of your work as in patient treatment." (Director of Nursing F)

Attitudes towards accounting – Restrictive or enabling factor

What was clearly observable from all of the interviewees was the fascination towards accounting information. One perspective was that it enables clinicians to understand how the organization is managed – to become more widely aware of common good than from they were from patient treatment sight. Accounting information was seen as a provider of linkage between the source of money and individuals' actions. Thus it helped to understand the scarcity of resources and the importance of realizing the consequences that ones actions would have.

"Enabling. In my opinion it eases the formation of the wider picture that numbers really have their meaning and money is the one moving there. Somehow when you realise that, you understand how it enables my job also. That numbers open the world completely differently so that even I can really look at what I'm doing. Everybody want's to do their job well." (Director of Nursing G)

Another perspective emphasized the importance to realize in what direction public health care should be aimed. They expressed genuine anxiety towards the growing demand of health services when large generations are aging in Finland. Clinicians (in administrative position)

perceived that thus hospital districts should accentuate the planning from financial perspective even in unit level. However they expressed the concern of making massive changes in methods suddenly as reacting rather than being proactive.

> *"I consider it as enabling factor really in the long run when we consider the future of health care. So, absolutely it is so that money shall not be adequate for everything, for everybody. Developing these things like accounting and extending it into our work has been a positive thing. I would hope it to occur gradually, not so that one day there comes a crisis reaction, that there comes a slicer and zack...rather than we would go further, develop and monitor our progress. Certain cost-awareness might be a positive factor. It can pull oneself together. But I would hope this to occur through evolution rather than through revolution."* (Associate Chief Medical Officer B)

Initial feedback when taking the first steps in learning management accounting skills was positive. Clinicians had noticed that they could understand beyond the figures, thus they were becoming more self-confident. Although as below quotation illustrates, that mentally the beginning of the role change process has been difficult.

> *"And as I have noticed here that it isn't that unfamiliar. I've allowed myself in it eventually in a positive attitude...that you can notice that I'm able to see the sensibility in economic follow-up. I have justified it that it is involved with legitimate usage of resources and in a way of restructuring these activities...I've ultimately agreed to this and taken it ultimately positively."* (Chief Medical Officer A)

One of the major problems that the organization has faced is the inefficient information systems. When clinicians haven't had the tools of learning how to exploit the accounting information, even when they have voluntarily tried it, there has been a strong incentive to ignore the systems. Also as in previous chapters was presented the former leader of the Department of Psychiatry didn't emphasize the leadership by numbers. Hence the organization hasn't undergone the culture where management accounting would have been integrated among clinicians. The senior

clinicians expressed, based on above mentioned reasons, positive expectations towards ongoing HUS strategy renewal project.

> *"Of course when you consider it from financial perspective, then we haven't had the right tools. But now there ought to come. I've been here almost three years and in a way missed the information, that there would come a financial report and that they would be in use. Performance information we do have from one policlinic and those we have been able to exploit. But now we are getting information of personnel costs and others. It is a good thing. One aspect is of course the financial responsibility but now we are getting the proper tools. Earlier we only knew the education and job control allocation, but now it expands."*
> (Director of Nursing G)

The mentality among interviewees was that accounting information would bring additional value to their work; after all they were being made financially responsible. They had encountered problems in altering their identity away from patient treatment towards administrative person, but they recognized a strong transition in themselves.

The results here were the same as in the beginning of Kurunmäki's (2004) research, although almost 10 years has passed after their data collection. The new millennium has been an era of constant renewals in HUS, where financial responsibility has been tried to implement to clinicians but the organization is currently again in same implementation phase. The question rises whether this new strategy project is able to do something where previous attempts have failed. At least current conceptions are positive and supporting among clinicians.

4.3.2 Indicators of polarization

As in theory section was illustrated, the fundamental difference between hybridization and polarization is, whether clinicians are commonly committed to accounting or would there become a sub-group of medical managers. If there would be evidence from polarization, the theory suggests, that there should be a strong dispersion into two groups: the first would ignore

accounting information and would focus on patient treatment and the second would acquire management accounting knowledge and become a hybridized profession.

Traditionally in public health care sector the academic research has been the key to more challenging and also to management positions. This is the path for physicians who have been and are currently in top management. It has been dependent on personal emphasis of how they perceive administrative tasks, and thus there is variation in attitudes. Some of them strongly experience themselves purely as clinicians and thus don't even want to be involved in management duties, as below quotation shows:

> *"There is no strong resistance towards the (role) change; it is more a question of seeking one's way. Some are more ready for it and there are also physicians who are definitely willing to stay purely as clinicians and so they are. They remain in that role until the end and I know a couple of them who retire from a pure patient treatment position. There is something enviable in it..."* (Chief Medical Officer A)

The fundamental problem in changing the physicians' role was explained by the oath of Hippocrates[4]. By following it strictly there would be antitheses of considering patient treatment in the perspective of resource constraints. Thus they would encounter the dilemma of being a healer or a manager.

> *"...the challenge is surely a question of personal integrity. That can you in your mind experience of being a physician and in a way can the role be composed so that you are a person under the oath of Hippocrates and on the same time you control these new things. And if you answer positively to this challenge, it does actually quite good for you, because then you create an image where you are responsible under the oath for the whole society, meaning the population. And that is measured for financial figures are only devices, devices between allocating recourses and justice."* (Chief Medical Officer A)

[4] The earliest ethical guidance for physicians by Hippocrates (460 B.C. – 370 B.C.) of which they are obliged to commit, see more from Saarni (2005)

Nurses approached this theme more from hybridization perspective, unlike physicians who had stronger variation between the perspectives at the same hierarchical level. Nurses experienced that in senior positions they would become automatically more involved with managerial tasks and thus accounting information. Although they supported hybridization ideology on horizontal level, they did give evidence of polarization on vertical level. If nurses in senior level would deal with accounting information they wished that persons with patient contacts wouldn't have to consider these.

> *"But otherwise as a rule, in my opinion, that people in line duties, meaning basic nursing level in their standard tasks shouldn't be obliged to focus on it, but could concentrate on the patient."* (Director of Nursing F)

Strong evidence was found to support polarization. Physicians indicated it more on horizontal level when nurses emphasized the vertical dispersion. Both nevertheless illustrated the existence of dispersion into two opposite groups.

4.3.3 Management accounting adaptation

In previous chapters was illustrated that the Department of Psychiatry encountered difficulties in implementing management accounting into clinicians use. Nominally the organization has the instruments of guiding the management. HUS has taken e.g. balanced scorecard in use and those have been tried to implement in unit level. In the ongoing strategy project HUS is updating scorecards in unit level and even personal scorecards shall be introduced. Thus clinicians are to be bound to measurable operation.

> *"Well, we do have this balanced scorecard (BSC) thinking in here. That we have made scorecards and of course cared for the idea behind BSC. BSC is familiar in that has been practiced here. In some units we are more advanced than in other. In a bit of different phases, but everybody should be familiar with BSC. I think that it'll direct our actions more in future and surely we are going to get more demanded."* (Director of Nursing G)

However, as below quotation indicates that although scorecards have been accepted on an idea level, their function is still shallow. It was described that although scorecards were apparently in use, they were not fully exploited. As if they were implemented without mapping their applicability and requirements.

> *"I haven't faced anybody who would be directly against it. But I think that we haven't always stopped to consider of what it should mean or what it could mean. I think that there are some minor deficiencies."* (Director of Nursing G)

Overall the adaptation process was seen as a leadership challenge. Clinicians perceived accounting and medicine highly discrete and how they could be combined, hybridized was dependent on how the top management introduces and emphasizes their mixed usefulness. Previously the importance of financial knowledge was not accentuated by the Department's management and thus still strong prejudices existed.

> *"Like that, yes, yes. They are so far away from each other. It is although purely a question of leadership, towards that I lean. There we have a field of work; it is not any easy thing. People here tend to think that it is so personal when somebody is measuring what we do here. But isn't like that, rather it is a matter of the entity. Of course the management has their own duties and on clinical they have their own but they should come across in some point."* (Director of Nursing G)

From January 2008 the new management initiated the financial responsibility program, where accounting knowledge ought to be directed even into unit level. First time the whole management team together with Directors of Nursing and accounting personnel sat together and examined how their department was described in form of financial figures.

> *"There was the group controller, or expert along. Then there was our financial manager who opened those calculations. We looked at where negative figures are and which are on balance. And then we considerer what needs to be done, how we should react. And even I*

need more of basic training; what does this mean and how should we look at these numbers and how they should be interpreted. But it is a start." (Director of Nursing G)

The history indicates that financial awareness has varied on individual level. Those who have voluntarily been willing to understand accounting figures have done it, but there were no indication of broad acceptance on acquiring the new knowledge. This is the process that is currently ongoing. However interviewees expressed their desire to become more aware of the financial aspect. Thus the process has had a positive incentive.

Changing the professional role

Although financial responsibility wasn't commonly implemented the clinicians experienced that their roles had changed. The transition was supported by the dualism that exists in public health care sector: physicians were more involved with management tasks regardless of their hierarchical level, thus having the dual role. The more senior level they would achieve, the more administrative duties they would get. However physicians would retain the contact with patients. Nurses on the other hand would diverge from nursing the higher they would climb on hierarchical ladders.

"I think it in that way that we have here in our organization...physicians have the double role more, we don't so widely. On ward level, ward sisters have more of the double role. The problem there is that you have to be professional and strong person so that you are able to see the entity. So that money and treatment aren't at variance. You are obliged to make decisions and they have certain value that when I do this, I loose this." (Director of Nursing G)

Recent development illustrates that there would be signs of reducing the dualism. Apparently the changes in management have enabled, at least in some form, to open the conversation among professions. The pressure has been put on combining the competence between these expertises.

"But in certain an areas when you have been working longer and have learned to know others' duties, then we have managed to create a cross-professional conversation in our head of department meetings. So that there are not just the lines for nurses and physicians rather one common. Thus the role may have been changed in that they, that we emphasize joint responsibility. Everybody have their own space but we work together. So that Directors of Nursing don't just go for their own interests, like traditionally. But this direction it has gone and now I feel that we particularly call for the management duties and knowledge." (Director of Nursing G)

The problem which supports the dualism was observed as learning away from pure clinician role, or to be precise from physician and nurse role. They have experienced themselves strongly as members of their own profession, where they have had own professional organizations presenting their cases. Thus it has been and is still currently difficult to aim for common good, to see beyond jurisdictions.

"Yes, it is so in personal level that we have to learn away. I would perceive it as extending in some way...reaching the basic tasks, project beyond medicine; it is widening one's insights. Learning away yes, but also taking the distance from the first situation, sort of estranging and broadening. It is, I believe, in all leadership that when we lean towards office finance and business life situations, it is important in leadership to learn seeing the big picture, understanding the common need." (Chief Medical Officer A)

Nurses experienced their diverging from patient treatment as a draw-back, if the administrative tasks were seen challenging and motivating. But on an idea level they perceived themselves strongly as a representative of nursing. As below is explained, they had altered their role away from their basic tasks, from patient treatment.

"So that I'm not anymore purely a representative of nursing at all, though in my mind I am and also in my heart I am. Of course for my people I try to be that, but in reality I'm not. So in practice I'm completely something different...a representative of many things, because the variation. Yes, I'm a ward sister when being in hospital. So it is conceived and that I

would like to retain at least in the eyes of my staff. In practice there are enormous amount of everything else, so I will represent what ever elsewhere." (Senior Ward Sister D)

Satisfaction to current role

Interviewees experienced that their roles had altered from patient treatment into administrative tasks. Nurses highlighted the change more, like above was shown, due to their separation from patient treatment. They expressed the process more from accepting what is needed perspective. On the other hand many of the interviewed nurses expressed their career development as a result of descending. Thus they hadn't announced equally strong resistance towards changing their roles.

"Well, it doesn't anymore (arise negative feelings). I'm of course accepted the situation...I have accommodated myself in everything. And of course attitude plays a huge role that I have taken the stand that I'll do what it expected from me nowadays. But I think I'll surely practice my profession, patient treatment in my pension days. But from here I'll leave certainly." (Senior Ward Sister D)

What was equally common among the parties was the willingness to impact on ones surroundings. As in previous chapters was illustrated, clinicians on unit level didn't receive any specified financial information. Thus they felt that although they were obliged to control their unit's development, they didn't have the proper tools for it. That influenced negatively on their satisfaction to current role.

"More I would ask for, well, a bit more of that power to decide for personnel questions here. That...let's put it in this way, that not perhaps power to decide but some sort being heard. But not much, broadly speaking I'm well satisfied to my current job." (Associate Chief Medical Officer B)

When nurses emphasized more their role change, they also accentuated their contradictory role. They had received challenging, administrative tasks which were commonly seen motivating, but

the negative aspect was the lack of jurisdiction. The power was seen legitimated to physicians and thus intensifying hierarchical dispute. Thus even negative answers were given to satisfaction discussion.

> *"Well, perhaps I'm not. Well in that way, this work is really diversified, it is on the other hand quite ok, but the authority and responsibility don't entirely go side by side. And also the existing hierarchy, which is traditionally quite strong here. That is a fact which exists between professions also. Those might restrict us much."* (Director of Nursing G)

All of the interviewees considered that financial information is of key importance to develop their ability to understand the consequences of their actions but also improve their influencing possibilities. They had altered their basis for justification from clinical facts into quantitative world of ideas. Clinicians perceived that thus they could present solid, reasonable ground for their decisions and arguments.

> *"...but in reality I have noticed it, that when we do decisions or some problems are being solved, we need a common understanding also on financial things. It is a central factor here. That I've noticed also personally that it is much more acceptable to demand when you can look from the perspective of resources and comment from there. It nevertheless means that we need to understand how the entity operates. Then you can speak of common good and realise a little bit of what it costs and pays for it."* (Chief Medical Officer A)

There had been nevertheless improvement of how they exploited financial information, but the problem was that it was used basically as an instrument of explaining from the history perspective. The desire of turning the aspect around to develop management accounting as a tool of planning was presented. In below quotation the wish was captured well.

> *"Well, there has probably happened some development, but much more could happen. In a way I think that it isn't reactive explaining but proactive understanding of what is happening here and what does the money mean, what should be done here. Then we would be on more solid ground and would be heading forward."* (Director of Nursing G)

Altogether, accounting information was perceived as a solid basis to widen the perspective and thus for being able to communicate.

> *"Yeas, definitely we have more arguments supporting our messages. Just recently I searched for visit numbers so that I could justify my decisions. I like when I have something concrete. If I say that it is so, I need to have some sort of a prove why I'm saying so. It is like raising a child – you need to explain why it is not allowed to go there..."* (Director of Nursing F)

5 DISCUSSION

Miller et al. (2007) appealed that the dynamics of hybrid processes ought to be studied and that this can be attained by examining industry- and firm-specific practices that improve information progression and communication beyond organizational boundaries and experts. This study approached the appeal from expertise perspective. It aimed to update the findings from Kurunmäki (2004), when they argued that medicine and accounting were hybridized.

The inter-professional approach was introduced by Abbott (1988) when they appealed that professions should be studied as an interdependent entity rather than separate objects. They argued that in this entity abstract knowledge would be the success factor in order to avoid jurisdictional disputes and continuous competitive game. Kurunmäki (2004) continued that encounters of professions within the system can evolve in hybridization or as well in competition. A key role is played by how lateral information flow and discrete technique mobility among professions are organized.

Kurunmäki (2004) argued that in health care sector, where organizational culture was dominated by medical professionals and accountants were seen as secondary information providers, a fundamental transition was expected in the late 90s. By directing the responsibility of budget preparation to medical professionals, they were combined into calculation networks (Miller & Rose, 1991). The success factor in the hybridization was this voluntary basis of participation and the experimental nature of the process.

Our empirical findings support this ideology of positive attitudes towards management accounting implementation presented by Kurunmäki. Every interviewee believed that accounting information would serve as beneficial factor that would enable better readiness to negotiate. From one perspective clinicians believed that by seeing beyond the numbers they would be able to understand the scarcity of resources and the importance of realizing the consequences of one's

actions. The other emphasized that by controlling their own actions they would achieve autonomy.

What was seen important by Kurunmäki (2004) was the participation of medical professionals in the early phase of budgetary process. This commitment was also tightened by making clinicians responsible to municipal representatives and hospital management for keeping within their budgets. Kurunmäki continue that clinicians reacted positively to the change and even started to demand more influence on accounting information. Thus Chief Physicians and Ward Sisters were allowed to have an access to the accounting systems. Hybridization process had emerged from localized experiments and delegated budgets towards commitment and acquisition of financial accounting knowledge.

The role of the state became only a purchaser of the service, where public provision was to be substituted with competing independent providers (Kurunmäki, 2004). Thus, as Buxton et al. (1991) argue, hospitals were forced to develop their financial management systems in order to survive the encouraged competition. The evidence found here are in line with the municipalities' attitudes. They wanted clinicians to understand the scarcity of resources and thus direct the supervision of the actions to the instance who knows them best, clinicians. Thus we determined the impulse from municipality to attach clinicians into acquiring management accounting knowledge.

However, our empirical results strongly disagree with the intensiveness of hybridization argued by Kurunmäki (2004). Although interviewed clinicians had a positive attitude towards the importance of management accounting; they perceived their participation to financial administration highly constricted. We found evidence of several factors influencing on why the hybridization process hadn't evolved as in Kurunmäki's research.

As Hatch & Cuncliffe (2005) argued that visible marking of group boundaries has a strong influence on group identities, our evidence are consistent with them. In our case clinicians were frustrated because they couldn't get access to desired information or it demanded too much effort. When HUS was founded also new management systems were implemented. The

adaptation process however didn't provide the desired outcome: the standards were created on group level and they were not applicable on department level. On the Department level they had resource problems in accounting personnel thus having a negative impact on implementation. Also the dispersion of different units complicated the communication between clinicians and accountants. If the different occupational groups are not actively in contact, the question rises, how they can create trust between them and through that an operational entity?

More vital factor was the power relations among professionals. Abbott (1988) argued that professional groups frequently attain power by pulling it off from competing groups. At HUS there has been historically strong duality between physicians and nurses. The organization has lines for both groups in which they report and interact. That has had the effect of creating boundaries between professionals: nurses and doctors have their own chains from operational employees, through administrative personnel to own labour organizations. When physicians are concentrated on clinical aspect, nurses have more administrative perspective. That has also been emphasized in their education. Historically Directors of Nursing and Senior Ward Sisters have had the obligation to be involved into administrative tasks, thus nurses' prejudices towards accounting have been smaller. However in high management positions are mainly physicians who have the perspective of their own profession. And because physicians' career development is attached to their academic research their interest towards managerial duties was questioned by nurses. As Chreim et al. (2007) indicated the richness of struggles over professional demands may complicate the role change, where different groups focus on boundary negotiations.

As Chreim et el. (2007) argued, in order to enable the role change, actions and interactions among multidisciplinary professionals are obliged. Historically in the Department and in HUS there have been role battles between nurses and physicians. Also the role of accounting has been seen only as secondary information provider. However, these have led into a situation, where attitudes are changing. In the beginning of 2008 a new management team started working at the Psychiatric Department. Along with the new HUS strategy renewal work they have emphasized the importance of consciousness. They believe that if clinicians would understand the impacts of their actions correctly, that if something needs to be improved one should start the change from

looking in the mirror, then the attitudes will change. One part of the process is to make the management systems user-friendly.

Ibarra (1999) argued that professionals in role transition phase who are able detect role models can identify prospective identities and collect set of instruments of tacit knowledge, experiences and opinions which they can use in restructuring to a new role. In current case many of the interviewees mentioned the importance of further training at work place. They emphasized that arranged education had a positive impact in understanding the results of personal actions. Thus by joining those training sessions they were able to broaden their views. Another example was external models. Some of the interviewees had worked in different organizations with varying organizational behaviours. These examples were seen encouraging and had a positive impact on interviewed clinicians. They felt that they were more aware of the consequences of their actions when they could exploit financial figures. Thus by understanding the consequences of their actions the work itself becomes more motivating and it was possible to have an impact of how things are done, to experience the power of authority.

In Kurunmäki's (2004) research Chief Physicians perceived the acquisition of financial knowledge as an increasing factor of freedom in management of resources. As was expressed, now nobody couldn't hide oneself behind bureaucracy and accuse politicians – they were obliged to manage the financial resources and thus were responsible for their own actions. Accounting was seen as an important skill that would enable to answer to the market conditions and thus the training of financial knowledge would be demanded as a part of medical education. Our empirical evidence supports the ideology. All of the interviewees considered that financial information is of key importance to develop their ability to understand the consequences of their actions but also improve their influencing possibilities. They had altered their basis for justification from clinical facts into quantitative world of ideas. Clinicians perceived that thus they could present solid, reasonable ground for their decisions and arguments. There had been nevertheless improvement of how they exploited financial information, but the problem was that it was used basically as an instrument of explaining from the history perspective.

Where Kurunmäki (2004) demonstrated that accounting techniques and practices were acquired by all medical staff and thus modifying the nature of medical profession, Jacobs (2005) suggested the idea of polarization. The fundamental difference between hybridization and polarization is, whether all medical staff is included or just limited number of them. Until the current year the empirical evidence from the Department of Psychiatry strongly argue for existing polarization. Traditionally in public health care sector the academic research has been the key to more challenging and also to management positions. It has been dependent on personal emphasis of how they perceive administrative tasks, and thus there is variation in attitudes. Some of them strongly experience themselves purely as clinicians and thus don't even want to be involved in management duties. Nurses had controversial approach. Although they supported hybridization ideology on horizontal level (when progressing towards senior positions, the more administration would be involved), they did give evidence of polarization on vertical level. If nurses in senior level would deal with accounting information they wished that persons with patient contacts wouldn't have to consider these. The strategy project in HUS indicated ambition towards hybridization but it is too early to comment the actual implementation.

The history of HUS reminds more the evolution in UK than in Finland, where clinicians showed initially slightly positive interest of gaining management accounting knowledge, but the compulsory attitude towards utilization of reforms didn't persuade them. We didn't find evidence of pure hostility rather ignorance. Kurunmäki's (2004) argument for acceptance of accounting practices in Finland was less formalized and powerful accounting profession and management accounting was seen as transferable set of tools available for everybody willing, not just property of accountants. We agree that accounting was seen as a knowledge which clinicians could acquire if wanted. The attitudes towards it have been the restrictive factors in HUS's history.

Recently, although there have been signs of change in attitudes; the fascination towards accounting information had increased. Accounting information was seen as a provider of linkage between the source of money and individuals' actions. Thus it helped to understand the scarcity of resources and the importance of realizing the consequences that ones actions would have. By

understanding the new language clinicians experienced that they could have better access to decision making situations.

The results here were the same as in the beginning of Kurunmäki's (2004) research, although almost 10 years has passed after their data collection. The new millennium has been an era of constant renewals in HUS, where financial responsibility has been tried to implement to clinicians but the organization is currently again in same implementation phase. The question rises whether this new strategy project is able to do something where previous attempts have failed. At least current conceptions are positive and supporting among clinicians. As Kurunmäki argued the key importance is how lateral information flow and discrete technique mobility among professions are organized. The mentality among interviewees was that accounting information would bring additional value to their work; after all they were being made financially responsible. They had noticed that the information can be transferred to them if only the physical structures haven't encouraged the process.

6 CONCLUSION

This study aims to contribute to the existing hybrid literature by improving our understanding of the adoption process of management accounting by medical professionals. When medical expertise and accounting are mixed up, conventional and also hierarchical methods are insufficient (see Kurunmäki, 2004). As Miller et al. (2007) appealed, if we want to have more extensive insight of the hybrid processes we need to examine industry- and firm-specific practices that improve information progression and communication beyond organizational boundaries and experts.

This research approached the hybridization from the perspective illustrated by Kurunmäki (2004). They illustrated how in health care sector, where organizational culture was dominated by medical professionals and accountants were seen as secondary information providers, a fundamental transition would have taken place. The empirical evidence of Kurunmäki's (2004) study was collected in the first half of 1990s. Thus there was a need for an up-to-date inspection of how accounting and medicine have evolved after the birth of demonstrated hybridized profession.

On the contrary to Kurunmäki (2004) our empirical evidence doesn't support the idea of born hybrid profession. The key findings were:

- municipalities had demanded the financial responsibility to be directed to clinicians
- physical structures (information systems, physical location) limited clinicians to access the financial information
- strong jurisdictional disputes among clinicians weakened their cooperation thus having a negative impact on adapting management accounting
- recent changes in the organization have initiated positive attitudes towards acquiring accounting knowledge

The demand for clinicians acquiring management accounting was discovered and current attitudes were positive towards the adoption, but the difficulties inside the organization have a negative impact of taking the needed step. Thus our results are controversial to Kurunmäki's research.

This study encountered some limitations. As was illustrated in methodology chapter, criticism towards the quality of the research can be directed. When collecting data through interviews, researcher's physical presence can direct the conversation thus affecting the objectivity. Also from the quality perspective it might have been more reliable to increase the participants from physicians.

The HUS organization is going through an intensive renewal project, where financial responsibility is directed to unit level. The strategy project has only recently been initiated and thus it is too early to make conclusions of acceptation or rejection. It would be interesting to examine how the situation will evolve in a time period of 2-5 years because of the negative attitudes towards hybridization in the past.

REFERENCES

Abbott, A. 1988. *The system of professions: an essay on the division of expert labor*. Chicago: University of Chicago.

Ashforth, B. E. 2001. *Role transitions in organizational life: An identity-based perspective*. Mahwah, NJ: Erlbaum.

Barley, S. R., Freeman, J. & Hybels, R. C. 1992. Strategic alliances in commercial biotechnology. In Nohria, N. & Eccles, R. G. (Eds.). *Networks and organizations*. Boston, MA: Harvard Business School Press.

Borys, B. & Jemison, D. B. 1989. Hybrid arrangements as strategic alliances: Theoretical issues in organizational combinations. *Academy of Management Review*. 14. 2, 234–249.

Bruns, W. J. Jr. & Kaplan, R. S. (Eds). 1987. Introduction: Field studies in management accounting. In *Accounting & Management: Field Study Perspectives*. Boston, MA: Harvard Business School Press.

Buxton, M., Packwood, T. & Keen, J. 1991. *Final report of the Brunel University evaluation of resource management*. HERG Research Report No. 9.

Chreim, S. 2002. Influencing organizational identification during major change: A communication based perspective. *Human Relations*. 55. 9, 1117–1137.

Chreim, S., Williams, B. E. & Hinings, C. R. 2007. Interlevel influences on the reconstruction of professional role identity. *The Academy of Management Journal*. 50. 6, 1515–1539.

Collins, H. 1990. Ascription of legal responsibility to groups in complex patterns of economic integration. *The Modern Law Review*. 53. 6, 731–744.

Das, T. K. & Teng, B. 2001. Trust, control and risk in strategic alliances: an integrated framework. *Organizational Studies*. 22. 2, 251–283.

De Beelde, I. 2002. Creating a profession 'out of nothing'? The case of the Belgian auditing profession. *Accounting, Organizations and Society*. 27. 4–5, 447–470.

Dekker, H. C. 2004. Control of inter-organizational relationships: evidence on appropriation concerns and coordination requirements. *Accounting, Organizations and Society*. 29. 1, 27–49.

Denis, J-L., Lamothe, L., Langley, A., & Valette, A. 1999. The struggle to redefine boundaries in health care systems. In Brock, D., Powell, M. & Hinings, C. R. (Eds.). *Restructuring the professional organizations: Accounting, health care and law*. New York: Routledge.

Eccles, R. G. 1981. The quasifirm in the construction industry. *Journal of Economic Behavior and Organizations*. 2. 4, 335–357.

Enckell, M. 1998. *Organizational cultures of Finnish hospitals in change*. Helsinki: Hanken, Svenska Handelshögskolan, Economi and Samhälle, No. 71.

Ferreira, L.D., & Merchant, K.A. 1992. Field research in management accounting and control: A review and evaluation. *Accounting, Auditing and Accountability Journal*. 5. 4, 3–34.

Fiol, C. M., & O'Connor, E. J. 2006. Stuff matters: Artifacts, social identity, and legitimacy in the U.S. medical profession. In Rafaeli, A. & Pratt, M. G. (Eds.). *Artifacts and organizations: Beyond mere symbolism*. Mahwah, NJ: Erlbaum.

Gulati, R. 1995. Does familiarity breed trust? The implications of repeated ties for contractual choice in alliances. *Academy of Management Journal*. 38. 1, 85–112.

Gulati, R., Nohria, N., & Zaheer, A. 2000. Strategic networks. *Strategic Management Journal*. 21. 3, 203–215.

Hatch, M. J., & Cunliffe, A. L. 2006. *Organization theory: Modern, symbolic and post-modern perspectives*. Oxford, U.K.: Oxford University Press.

Hirsjärvi, S., Remes, P. & Sajavaara, P. 2005. *Tutki ja kirjoita*. Jyväskylä: Gummerus Kirjapaino Oy.

Holmström, B. & Roberts, J. 1998. The boundaries of the firm revisited. *Journal of Economic Perspectives*. 12. 4, 73–94.

Hood, C. 1995. The "New Public Management" in the 1980s: Variations on a theme. *Accounting, Organizations and Society*. 20. 2–3, 93–109.

Hopwood, A. G. 1983. On trying to study accounting in the contexts in which it operates. *Accounting, Organizations and Society*. 8. 2–3, 287–305.

Hopwood, A. G. 1984. *Accounting and pursuit of efficiency*. In Hopwood, A. G., & Tomkins, C. (Eds.). Issues in public sector accounting. London: Philip Allen.

Hopwood, A. G. 1996. Looking across rather than up and down: On the need to explore the lateral processing of information. *Accounting, Organizations and Society*. 21. 6, 589–590.

Ibarra, H. 1999. Provisional selves: Experimenting with image and identity in professional adaptation. *Administrative Science Quarterly*. 44. 4, 764–791.

Jacobs, K. 1998. Costing health care: A study of the introduction of cost and budget reports into a GP association. *Management Accounting Research*. 9. 1, 55–70.

Jacobs, K. 2005. Hybridisation or polarisation: doctors and accounting in the UK, Germany and Italy. *Financial Accountability & Management*. 21. 2, 135–161.

Joutsivuo, T. & Laakso, M. 2008. *Sairaanhoidon ytimessä: HYKS 50 vuotta*. Helsinki: Edita Publishing Oy.

Keating, P. J. 1995. A Framework for classifying and evaluating the theoretical contributions of case research in management accounting. *Journal of Management Accounting Research*. 7, 66–68.

Keefer, P. & Knack S. 2002. *Social polarization, political institutions and country creditworthiness*. World Bank Working Paper. Washington: World Bank.

Kurunmäki, L. & Miller, P. 2004. *Modernisation, partnerships and the management of risk*. Discussion Paper No. 31. London: Centre for Analysis of Risk and Regulation.

Kurunmäki, L. 2004. A hybrid profession – The acquisition of management accounting expertise by medical professionals. *Accounting, Organizations and Society*. 29. 3–4, 327–347.

Kurunmäki, L., Melia, K., & Lapsley, I. 2003. Accountingization v. legitimation: A comparative study of the use of accounting information in intensive care. *Management Accounting Research*. 14. 2, 112–139.

Kurunmäki, L., Melia, K., & Lapsley, I. 2006. *Costs, care and rationing: A comparative study of intensive care in the UK and Finland*. London: CIMA.

Langfield-Smith, K. & Smith, D. 2003. Management control systems and trust in outsourcing relationships. *Management Accounting Research*. 14. 3, 281–307.

Latour, B. 1993. *We have never been modern*. London: Harvester Wheatsheaf.

Luke, R. D., & Walston, S. L. 2003. Strategy in an institutional environment: Lessons learned from 1990s "revolution" in health care. In Mick, S. S. & Wyttenbach, M. E. (Eds.). *Advances in health care organization theory*. San Francisco: Jossey-Bass.

Lukka, K. & Kasanen, E. 1995. The problem of generalizability: anecdotes and evidence in accounting research. *Accounting, Auditing & Accountability Journal*. 8. 5, 71–90.

McKinnon, J., 1988. Reliability and validity in field research: Some strategies and tactics. *Accounting, Auditing & Accountability Journal*. 1. 1, 34–54.

Miller, P. & O'Leary, T. 2007. Mediating instruments and making markets: Capital budgeting, science and the economy. *Accounting, Organizations and Society*. 32. 7–8, 701–734.

Miller, P., Kurunmäki, L. & O'Leary, T. 2007. Accounting, hybrids and the management of risk. *Accounting, Organizations and Society*. In press.

Miller, P. & O'Leary, T. 2005a. Managing operational flexibility in investment decisions: The case of Intel. *Journal of Applied Corporate Finance*. 17. 2, 87–93.

Miller, P. & O'Leary, T. 2005b. *Capital budgeting, co-ordination, and strategy: A field study of inter-firm and intra-firm mechanisms*. In Chapman, C. (Ed.). Controlling strategy. Oxford: Oxford University Press.

Miller, P. & Rose, N. 1991. *Programming the poor: poverty calculation and expertise*. In J. Lehto (Ed.). Deprivation, social welfare and expertise, National Agency for Welfare and Health. Research report no. 7. Helsinki: Finnish Government Printing Centre.

Miller, P. 1998. The margins of accounting. *The European Accounting Review*. 7. 4, 605–621.

Olson, O., Guthrie, J., Humphrey, C. (Eds.). 1998. *Global warning! debating international developments in new public financial management*. Oslo: Cappelen Akademisk Forlag as.

Ouchi, W. G. 1979. A conceptual framework for the design of organizational control mechanisms. *Management Science*. 25. 9, 833–848.

Powell, W. W. 1985. *Getting into the print: The decision making process in scholarly publishing*. Chicago, IL: University of Chicago Press.

Powell, W. W. 1987. Hybrid organizational arrangements: New form or transitional development? *California Management Review*. 30. 1, 67–87.

Powell, W. W. 1990. Neither market nor hierarchy: Network forms of organization. *Research in Organizational Behavior*. 12, 295–336.

Powell, W. W., Koput, K. W. & Smith-Doerr, L. 1996. Interorganizational collaboration and the locus of innovation networks of learning in biotechnology. *Administrative Science Quarterly*. 41. 1, 116–145.

Pratt, M. G. & Dutton, J. E. 2000. Owning up or opting out: The role of emotions and identities in issue ownership. In Ashkanasy, N., Hartel, C. & Zerbe, W. (Eds.). *Emotions in the workplace: Research, theory and practice*. Westport, CT: Quorum Books.

Pratt, M. G., Rockmann, K. W., & Kaufmann, J. B. 2006. Constructing professional identity: The work of role and identity learning cycles in the customization of identity among medical residents. *Academy of Management Journal*. 49. 2, 235–262.

Reay, T. K., & Hinings, C. R. 2005. The recomposition of an organizational field: Health care in Alberta. *Organization Studies*. 26. 3, 351–384.

Roberts, J. 2004. *The modern firm: Organizational design for performance and growth*. Oxford: Claredon.

Rose, N. & Miller, P. 1992. Political power beyond the State: problematics of government. *The British Journal of Sociology*. 43. 2, 173–205.

Ryan, B., Scapens, R. W. & Theobald, M. 2002. *Research Method and Methodology in Finance and Accounting*. Thomson. Great Britain: Cornwall.

Saarni, S. 2005. *Lääkärin etiikka*. Joensuu: PunaMusta Oy.

Scapens, R. W., 1990. Researching management accounting practice: the role of case study methods. *British Accounting Review*. 22. 3, 259–281.

Van der Meer-Kooistra, J. & Vosselman, E. 2000. Management control of interfirm transactional relationships: the case of industrial renovation and maintenance. *Accounting, Organizations and Society*. 25. 1, 51–77.

Williamson, O. E. 1991. Comparative economic organization: The analysis of discrete structural alternatives. *Administrative Science Quarterly*. 36. 2, 269–296.

Zaheer, A. & Venkatraman, N. 1995. Relational governance as an interorganizational strategy: An empirical test of the role of trust in economic exchange. *Strategic Management Journal*. 16. 5, 373–392.

Interviews:

Chief Medical Officer A	24.4.2008	64min
Associate Chief Medical Officer B	29.4.2008	49min
Leading Director of Nursing C	30.4.2008	49min
Senior Ward Sister D	7.5.2008	51min
Controller E	12.5.2008	50min
Director of Nursing F	13.5.2008	55min
Director of Nursing G	13.5.2008	50min

Additional information:

HUS annual report 2006

HUS annual report 2007

www.hus.fi (Figure 2. and Appendix 1.)

APPENDICES

Appendix 1. HUS hospitals (source: www.hus.fi)

Appendix 2: Framework for the interviews

Preliminary information:

- Age
- Education

1. Overview

Objectives:
Introduce interviewee to the theme by exploring person's career path
Explore the current perspective of interviewee's role and motivation

- How would you describe your job and how has it evolved during the last 10 years?
- Do you perceive yourself as a representative of medicine or as an administrative person?
- Were you originally interested in administrative tasks or did you prefer clinical duties?

2. **Hybridization process – Institutional dynamics**

Objectives:
Examine the forces affecting the organization in implementing financial coordination to clinicians
Understand the current directions of hybridization

- How would you describe your job evaluation 10 years ago; who coordinated the finance?
- In your opinion why changes have been adopted and who have been the key driving forces?
- How is financial coordination organized currently in your organization?

3. **Organizational dynamics**

Objectives:
Find out the perspectives towards hybridization in the chosen case organization
Probe the evolution of hybridization in organizational context

- Have financial administration and coordination been introduced here to clinicians? If yes, what were the initial reactions?
- Who did participate in transformation process?
- In your perspective, how has the process succeeded? What were the factors affecting the success/decline?

4. **Personal dynamics**

Objectives:
Induce the discussion from objective perspective to subjective
Explore the individual conceptions towards finance

- What was your personal reaction to financial administration and coordination?
- How would you perceive the learning process (accounting tools)? What were the major challenges?
- How has your role changed?

5. **Major threats and concerns**

Objectives:
Research the change in clinicians' role
Discuss the anxities and delights of the hybridization process

- Do you perceive financial information as restricting or enabling factor?
- Are clinicians able to have financial coordination responsibility or is separate financial department needed?
- Are you satisfied with your current role? Why?
- Do you perceive your negotiation power increased or decreased during the process?